

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 may be retained by the hospital or attending physician, and completed and filed by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00749  
00744

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>12 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>6425 Blenheim Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT OGIER ABURN</b>		4. DATE OF DEATH <b>January 12, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 12, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Furniture Manufacturer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Manufacturing</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Johnson B. Aburn</b>		14. MOTHER'S MAIDEN NAME <b>Minnie F. Stoll</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-7602</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Chronic glomerulonephritis</b> DUE TO (c) <b>Regional enteritis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>5 years</b> <b>12 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>December 31, 1961</b> to <b>January 12, 1962</b> , that (we) last saw the deceased alive on <b>Jan. 12, 1962</b> , and that death occurred <b>11:17AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William B. Kremer</b> M.D.		22b. DATE SIGNED <b>1/12/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>William B. Kremer, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-15-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenmount</b>		23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>			

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Montgomery

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12 days

The Clinical Center

The Clinical Center

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, and Page 4 to the Funeral Director. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL CERTIFICATION

Burial-transit 1-20-62

23. FUNERAL DIRECTOR  
ROBERT A. PUMPHREY  
ADDRESS  
Bethesda, Maryland

24a. REC'D BY REGISTRAR  
JAN 23 '62

24b. REGISTRAR'S SIGNATURE  
Arthur D. Hanks

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00784 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Hgts.						b. COUNTY Montgomery					
c. LENGTH OF STAY IN 1b 4 mos.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Echo Hgts., Maryland 58					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6015 Walhonding Rd.,						d. STREET ADDRESS 6015 Walhonding Rd.,					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Helen			First Helen			Middle C.			Last Adelman		
5. SEX Female			6. COLOR OR RACE White			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH March 10, 1892		
9. AGE (In years last birthday) 69			IF UNDER 1 YEAR Months Days Hours Min.			IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY None					
11. BIRTHPLACE (State or foreign country) New York, N.Y.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Wm. Henry Carlock						14. MOTHER'S MAIDEN NAME Amanda Berrel					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT Dr. Atelman						Address 6015 Walhonding Rd.,					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) History of C.Va. in distant past.											
INTERVAL BETWEEN ONSET AND DEATH Found dead in bed.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 1-20-62											
ACTUAL SIGNATURE Frank J. Broschart						M.D.					
EXAMINER'S NAME (Type)						Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 1-20-62						22b. DATE THEREOF					
22c. NAME OF CEMETERY OR CREMATORY St. Bernards						22d. LOCATION (City, town, or country) (State) Bernardsville, New Jersey					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was in the hospital or nursing home, the certificate may be completed by the attending physician and completely filled in by the general director. If the deceased was not in the hospital or nursing home, the certificate must be completed by the attending physician and completely filled in by the general director. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> c. LENGTH OF STAY IN 1b <b>20 YRS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7117 SYCAMORE AVE.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b> d. STREET ADDRESS <b>7117 SYCAMORE AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence Conduct</b> First Middle Last		4. DATE OF DEATH <b>1 30 1962</b> Month Day Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR 19 1880</b> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEMAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (County & State, or foreign country) <b>NEW YORK CITY N.Y.</b>
13. FATHER'S NAME <b>JOHNATHAN D. CONDUCT</b>		14. MOTHER'S MAIDEN NAME <b>EMILY TUTTLE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>KATHRINA C. BALDWIN, 29 CRESCENT BL.</b>		Address <b>MADISON N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized carcinomatosis</b> 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>uterine carcinoma</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1 1960</b> to <b>Jan. 30 1962</b> that (I) (we) last saw the deceased alive on <b>Jan. 30 1962</b> , and that death occurred at <b>6:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Mesimund B Pano, M.D.</b>		22b. DATE SIGNED <b>1/30/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>MESIMUND B PANOS</b>		22d. ADDRESS <b>1726 Eye St. NW Washington DC</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE THEREOF <b>FEB 2 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FLINCOLN CREMATORY</b>	23d. LOCATION (City, town or county) (State) <b>PRINCE GEORGES Co., Md.</b>
24. GENERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>		25a. REC'D BY REGISTRAR <b>[Signature]</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00751

00746

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Derwood R.F.D.#1</u> c. LENGTH OF STAY IN 1b <u>5 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ammons Nursing Home</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney, Maryland</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Harriet</u>		First Middle Last <u>Allen</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>January 16, 19 62</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>Col</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <u>5-10-1880</u>		<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>			
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Maryland</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Andrew Burke</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizebeth Wallace</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Nursing Home Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decompensation.</u> <u>422.1</u> DUE TO (b) <u>Chronic Myocarditis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>10</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov. 1, 1961</u> <b>to</b> <u>1/16</u> , 19 <u>62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/15</u> , 19 <u>62</u> , <b>and that death occurred at</b> <u>5:30</u> <b>from the causes and on the date stated above.</b>							
<b>22a. SIGNATURE</b> <u>Luciano I. Leal M.D.</u> M.D.				<b>22b. DATE SIGNED</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Luciano I. Leal M.D.</u>				<b>22d. ADDRESS</b>			
<b>23a. BURIAL, CREMATION, RURAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/19/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Zion.,</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Mt. Zion, Md.</u>		<b>(State)</b>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u>				<b>25a. REC'D BY REGISTRAR</b> DATE <u>JAN 18 '62</u>			
<b>ADDRESS</b> <u>Rockville, Md.</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Howe</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be completed by the hospital or attending physician. Part II should be completed by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1/12/52  
Mr. J. H. ...  
Mr. J. H. ...

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00752

011747

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN b. <b>3 yrs. 1 mo.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>--</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington,</b> d. STREET ADDRESS <b>1412 Webster St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Helen Lyston Aman</b>		4. DATE OF DEATH Month Day Year <b>January 27 19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/27/1879</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>47X 3</b>	
11. IF UNDER 24 HRS. Hours Min. <b>15 0</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Lyston</b>		14. MOTHER'S MAIDEN NAME <b>Mary B. Eagan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give year or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Benjamin Guy-</b>		Address <b>1001 Tower Building Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Shock</b> <b>493X</b> DUE TO <b>myocardial failure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <b>Pneumonia</b> DUE TO <b>1 min.</b> <b>4 days</b> <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semility - arteriosclerotic cardiovascular disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <b>1 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Dissect</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956 to 26 Jan., 1962</b> that (I) <b>was</b> last saw the deceased alive on <b>26 Jan. 19 61</b> and that death occurred at <b>4:30 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Horace W. Bernton</b> 22c. PHYSICIAN'S NAME (Type) <b>Horace W. Bernton</b>		22b. DATE SIGNED <b>4743 Bendly Blvd, Chk 15, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1/30/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The J.H. Hines Co.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 30 '62</b>	
ADDRESS <b>2901 14th St. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Conrad E. Hesse</b>	

(M)

10152

McDonnell

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3000 McDonnell Avenue  
Washington, D.C. 20008

John McDonnell  
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Washington, D.C. 20008

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Washington, D.C. 20008



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00748

FOR STATE HEALTH DEPT.

NO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN It <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM HOSPITAL</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institut on; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1206 Quebec Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Salvatore (Sam) Amato</u>		<b>4. DATE OF DEATH</b> Year <u>1962</u> Month <u>1</u> Day <u>24</u>		<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>W</u>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>1-18-1901</u>		<b>9. AGE</b> (In years last birthday) <u>61</u> yrs. IF UNDER 1 YEAR: Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min. IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BARBER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Palermo Sicily</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>AMERICAN</u>		<b>13. FATHER'S NAME</b> <u>Salvatore Amato</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine Vitale</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT</b> <u>Mrs. Salvatore BARRNCA Silver Spring St.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 422.2 DUE TO (b) <u>Chronic myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT COND.TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of Injury in Part I or Part I of item 18.)							
<b>20c. TIME OF INJURY</b> Hour <u>19</u> p.m. Month, Day, Year		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DATE SIGNED</b> <u>1-24-62</u>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>		<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschart</u>					
<b>22a. BURIAL, CREMATION, REMOVAL, or Specify</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>1/27/62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. MARY'S</u>			
<b>22d. LOCATION</b> (City, town, or country) <u>WASHINGTON, D.C.</u>		<b>23. FUNERAL DIRECTOR</b> <u>W.W. Chambers Co. Silver Spring Md.</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>JAN 29 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>					



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00755

00750

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookeville</u> c. LENGTH OF STAY IN 1b <u>2 Mo 11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Russell Rest Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring.,</u> d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert</u> <u>Awkward</u>		<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>12</u> Year <u>1962</u>		
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>colored</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct. 2, 1880</u>	<b>9. AGE</b> (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u>81</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Maryland</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>Presley Awkward</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Luvenia Powell</u>		
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Luvenia Warren:</u> Address <u>Ashton, Md.</u>
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Scrub pneumonia</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Advanced generalized atherosclerosis</u> (c) <u>due to</u> cause last, (e) <u>due to</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II (a)				
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Hour <u>19</u> m. <u>00</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, factory, street, office bldg., etc.)
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1942, to Jan 12, 1962, that (I) (we) last saw the deceased alive on Jan 2, 1962, and that death occurred at 11:00 A.M. from the causes and on the date stated above.</b>				
<b>22a. SIGNATURE</b> <u>A.D. Bonifant</u>		<b>22b. DATE SIGNED</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A.D. Bonifant</u>
<b>22d. ADDRESS</b> <u>Sandy Spring, Md.</u>				
<b>23a. BURIAL, CREMATION, REBURY</b>		<b>23b. DATE THEREOF</b> <u>1/17/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Sandy Spring.,</u>
<b>23d. LOCATION</b> (City, town or county) <u>Sandy Spring, Md.</u>		<b>23e. (State)</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Snowden</u>		<b>24b. ADDRESS</b> <u>Rockville, Md.</u>		<b>25a. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Thomas</u>
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Wm. S. Thomas</u>		<b>25c. DATE</b> <u>Jan 17, 1962</u>		

MEDICAL CERTIFICATE ON

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if not in residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			
c. LENGTH OF STAY IN lb <b>DOA</b>				d. STREET ADDRESS <b>12906 Georgia Ave.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hilda Bessie Bacher</b>				4. DATE OF DEATH Month Day Year <b>January 9, 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-16-1883</b> <b>4/15/1893</b>	
9. AGE (In years last birthday) <b>78</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife - own home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Iowa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Fritz Frohardt</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Beyer</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give year or dates of service)) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Phillip D. Bacher</b>		Address <b>Hyattsville, Md.</b> <b>8506 Allendale Rd.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Asystole</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stokes-Adams Syndrome</b> DUE TO (c) <b>Coronary Arteriosclerosis, severe</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>sudden</b> <b>unknown</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fell from back porch at home</b>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell from back porch at home</b>	
20c. TIME OF INJURY Month, Day, Year <b>10:25 xx 1/9 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Wheaton, Mont. Md.</b>		20f. (City or town) (County) (State) <b>Wheaton Mont. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Dr. Frank Broschart</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) <b>1-9-62</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1-11-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		22d. LOCATION (City, town, or country) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR <b>RA Ziska</b> <b>Warner E. Pumphrey Inc.</b>				24a. REC'D BY REGISTRAR <b>JAN 15 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>																			
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN TB <u>1 yr</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 N. Adams st.</u>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>mmt</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>108 N. Adams st.</u>														
<b>3. NAME OF DECEASED</b> (Type or print) <u>John</u> <u>Balogh</u>		<b>4. DATE OF DEATH</b> Month <u>Jan</u> Day <u>3</u> Year <u>1962</u>		<b>5. SEX</b> <u>male</u>			<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>										
<b>8. DATE OF BIRTH</b> <u>6-7-21</u>		<b>9. AGE</b> (in years last birthday) <u>40</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Barber</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Barber Shop</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.																	
Months	Days	Hours	Min.																
<b>13. FATHER'S NAME</b> <u>James Balogh</u>					<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Popomajer</u>														
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WW 11</u>					<b>16. SOCIAL SECURITY NO.</b> <u>102-12-6166</u>					<b>17. INFORMANT</b> <u>Rt.# 3 Box 89</u> <u>James Balogh- Sunset Lane, Lutz, Florida</u>									
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral contusions &amp; lacerations</u> DUE TO (b) <u>Fracture of skull</u> (c) <u>Fall and acute alcoholism</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>hrs.</u>									
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> <b>CAUSE OF DEATH.</b>					<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell down steps in front of his home entrance</u>														
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>Jan 3 1962</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Rockville</u>		<b>(County)</b> <u>Montg.</u>		<b>(State)</b> <u>Md.</u>									
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschatt</u> <b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschatt</u>					<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					<b>DATE SIGNED</b> <u>Jan 3 1962</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1/8/62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>22d. LOCATION (City, town, or country)</b> <u>Arlington, Virginia</u>													
<b>23. FUNERAL DIRECTOR</b> <u>Tyson Wheeler Funeral Home-1331 E. Mont. Ave.</u> <u>Rockville, Maryland</u>					<b>24a. REC'D BY REGISTRAR</b> <u>JAN 8 '62</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Robert L. Kline</u>												

MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be marked "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00758 Item 8 Film G305 1/11/62 ink

00753

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b. <b>0</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>North Carolina</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Grimesland</b> d. STREET ADDRESS <b>Rt #1 Box 168</b>	
3. NAME OF DECEASED (Type or print) <b>William BARBER</b>		4. DATE OF DEATH <b>Jan. 3 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negroid</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-10-29 1930</b>	
9. AGE (in years last birthday) <b>31</b> yrs.		10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>19</b> Hours <b>62</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Roofing</b>	
13. FATHER'S NAME <b>William H. BARBER</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta FOBBS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give war or dates of service)) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(S) Bertha L. JONES</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basilar Skull Fracture &amp; Laceration of Heart</b> DUE TO <b>902.12</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Fall from building (3 story)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), <b>Free 3 story from construction job - U.S. Naval Hosp.</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>3-20 p.m. 1-3 1962</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Construction job</b>		20f. (City or town) (County) (State) <b>Bethesda Monty Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Brosch</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Brosch</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF		Address (Street, city, town, or county) <b>Greenville, N.C.</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR <b>Popes Funeral Home, Washington, D. C.</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		DATE	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00759

CERTIFICATE OF DEATH

Reg. Dist. No. 00754

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Olney</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emory Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Barnsley</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 1, 1909</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Consignee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sinclair Oil</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Barnsley</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Platt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Mrs. Hazel Johns, Sister, Olney, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute &amp; Chronic Alcoholism</b> DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. 7.</b> Month <b></b> Day <b>19</b> Year <b>1962</b> p. m. <b></b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 1961, to <b>1/8</b> , 1962, that I last saw the deceased alive on <b>1/3</b> 1962, and that death occurred at <b>12:30 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Md.</b> DATE SIGNED <b>1/8/62</b> ACTUAL SIGNATURE <b>C. H. Higdon</b> M.D. <b>Sandy Spring, Maryland</b> PHYSICIAN'S NAME (Type) <b>C. H. Higdon</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Friends Meeting House Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Sandy Spring, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 11 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>C. H. Higdon</b>			





<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Philadelphia</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Philadelphia</u>	
c. LENGTH OF STAY IN 1b <u>5 days</u>		d. STREET ADDRESS <u>824 North Hilton Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, NIH</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Edward William Barth</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>Jan. 25 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>March 28, 1922</u>	
9. AGE (in years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck-loader</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpet</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Steven Barth</u>		14. MOTHER'S MAIDEN NAME <u>Clara Blakeley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWII</u>		16. SOCIAL SECURITY NO. <u>167-18-8697</u>	
17. INFORMANT <u>Clinical Center, Medical Record</u>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>			
410X DUE TO (b) <u>Rheumatic heart disease with</u>			
(c) <u>Aortic stenosis &amp; Mitral insufficiency</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>died while undergoing surgical anesthesia in preparation for heart surgery.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></b>			
CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <u>1-25-62</u>			
Address (Street, city, town, or county)			
<b>22. ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.			
<b>EXAMINER'S NAME</b> (Type) <u>FRANK J. Broschant</u>			
<b>22a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>BURIAL</u>			
<b>22b. DATE THEREOF</b> <u>1/30/62</u>			
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>NATIONAL CEMETERY</u>			
<b>22d. LOCATION</b> (City, town, or country) (State) <u>BEVERLY N.J.</u>			
<b>23. FUNERAL DIRECTOR</b> <u>W.W. CHAMBERS CO. 1400 CHAPIN ST. NW WASH DC</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>JAN 31 '62</u>			
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS AIS (4)  
ISM 9/59

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00761

00756

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>39 Silver Spring</b>	
c. LENGTH OF STAY IN 1b <b>3 years</b>		d. STREET ADDRESS <b>1816 Brisbane Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1816 Brisbane Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>THOMAS NCIAN BEALL</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>17th</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>June 15th, 1877</b>
<b>9. AGE</b> (In years last birthday) <b>84</b> yrs		<b>10. IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Building</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Silver Spring, Md.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Cornelius Beall</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Lucy O'Connor</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>None</b>		<b>16. SOCIAL SECURITY NO</b> <b>215-16-1889</b>	
<b>17. INFORMANT</b> <b>Wilbur T. Beall, 9209 Saybrook Ave. Sil.Sp., Md.</b>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>4</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO (b) <b>Atherosclerosis</b> Condit. and, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Hypertension</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 wkr</b> <b>?</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>10 Jan 1962</b> <b>to</b> <b>17 Jan 1962</b> <b>that (I) (we) last saw the deceased alive on</b> <b>16 Jan 1962</b> <b>and that death occurred at</b> <b>4:14 p.m.</b> <b>from the causes and on the date stated above</b>			
<b>22a. SIGNATURE</b> <b>William D. Aud</b>		<b>22b. DATE SIGNED</b> <b>1/17/62</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>William D. Aud</b>		<b>22d. ADDRESS</b> <b>9008 Colesville Road, Silver Spring, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/20/1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>George Washington Cemetery Riggs Rd. Extd., Hyattsville, Md.</b>		<b>23d. LOCATION (City, town, or county)</b> <b>Pr. Geo. Co.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>N.W. Chambers, Inc. Silver Spring, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 25 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>C. S. S. Harris</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00762

00757

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>MONTGOMERY</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admision) <b>a. STATE</b> <b>MARYLAND</b>		<b>b. COUNTY</b> <b>MONTGOMERY</b>	
<b>b. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		<b>c. LENGTH OF STAY IN 1b</b> <b>APROX. 11 HRS.</b>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
<b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		<b>e. IS RESIDENCE ON A FARM?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		<b>d. STREET ADDRESS</b> <b>Rt. 3 Box 307</b>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>JAMES W. BEERS</b>		<b>4. DATE OF DEATH</b> <b>1 4 19 62</b>		<b>5. SEX</b> <b>MALE</b>	
<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>4/10/69</b>	
<b>9. AGE</b> (In years last birthday) <b>92</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>PENNSYLVANNIA</b>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PENNSYLVANNIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>GEORGE W. BEERS</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>ELLEN RICHEY</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>HOSPITAL RECORDS</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>BILATERAL BRONCHOPNEUMONIA. with abscess</b> <b>420.0</b> <b>DUE TO</b> <b>Arterio sclerotic heart disease</b> <b>yrs.</b> <b>CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.</b> <b>DUE TO</b> <b>ARTERIOSCLEROTIC HEART DISEASE.</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>days</b>		<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <b>ARTERIOSCLEROTIC HEART DISEASE.</b>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Hour <b>a.m.</b> <b>p.m.</b> <b>19</b>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> <b>Not While</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/> <b>at work</b> <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. City or town</b> <b>20g. County</b> <b>20h. State</b>		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1/3/62</b> <b>11:30A</b> <b>19</b> <b>to</b> <b>1/4/62</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>1/4/62</b> <b>19</b> <b>and that death occurred at</b> <b>M</b> <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <b>F. J. Broschart</b> <b>M.D.</b>	
<b>22b. ADDRESS</b> <b>GAITHERSBURG, MARYLAND</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>F. J. Broschart, M.D.</b>		<b>22d. DATE SIGNED</b> <b>JAN 8 1962</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>23b. DATE THEREOF</b> <b>1-7-62</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Forest Oak</b>	
<b>23d. LOCATION</b> (City, town or county) <b>Forest Oak</b>		<b>23e. REC'D BY REGISTRAR</b> <b>JAN 8 1962</b>		<b>23f. REGISTRAR'S SIGNATURE</b> <b>John D. Hays</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
c. LENGTH OF STAY IN 1b <u>9 yrs</u>		d. STREET ADDRESS <u>6919 Stratmore st</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6919 Stratmore st</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George A. Bentley</u>		4. DATE OF DEATH <u>Jan 31 1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-80</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. U.S.A.</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
10a. BIRTHPLACE (State of foreign country) <u>U.S.A.</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. FATHER'S NAME <u>GEORGE A. BENTLEY</u>		12. MOTHER'S MAIDEN NAME <u>PLANTE</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW 1 &amp; 2</u>		14. SOCIAL SECURITY NO. <u>Yes-Unknown</u>	
15. INFORMANT <u>Marion H Bentley (wife) Item 2</u>		16. ADDRESS <u>Stem 2</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420-1</u> DUE TO (b) <u>Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>yes</u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>yes</u>			
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-31-62</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 7 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00764 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00758

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 4 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6807 Connecticut Avenue</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> d. STREET ADDRESS <u>6807 Connecticut Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louis F Bessey</u>		<b>4. DATE OF DEATH</b> <u>January 5 1962</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Dec. 27, 1892</u> 9. AGE (In years, last birthday) <u>69</u> yrs. <u>0</u> Months <u>8</u> Days <u></u> Hours <u></u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u> 11. BIRTHPLACE (State or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and dates of service) <u>Yes WW 1</u> 16. SOCIAL SECURITY NO. <u>Yes-Unknown</u> 17. INFORMANT <u>Mrs. Browning-Step daughter</u> Address <u>Bethesda, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO (b) <u>1st, 2nd &amp; 3rd degree burns resulting from</u> (c) <u>about 90° F of body</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bird caught alive - Reported smoking in bed.</u> 20c. TIME OF INJURY Month, Day, Year <u>5:15 - 1-5-1962</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Chevy Chase</u> (County) <u>Montgomery</u> (State) <u>Md.</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u> EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1-5-62</u>			
22e. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>			
22d. LOCATION (City, town, or country) <u>Rockville, Maryland</u>		24e. REC'D BY REGISTRAR <u>JAN 8 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>							



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

00765

00759

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>			d. STREET ADDRESS <u>Queenstown</u>		
3. NAME OF DECEASED (Type or print) <u>William Harrison Bishop</u>			4. DATE OF DEATH Month <u>January</u> Day <u>26</u> Year <u>1962</u>		
5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>January 18, 1884</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Used Car Business</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		
13. FATHER'S NAME <u>William Bishop</u>			14. MOTHER'S MAIDEN NAME <u>Florence Harrison</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-32-7480</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Edema</u> <u>+ 2 0 1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Old Coronary Occlusion</u> (c) <u>Acute Coronary Occlusion</u> cause last } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Arteriosclerosis</u>			17. INFORMANT Address <u>Washington Sanitarium and Hospital Records</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 21, 1962</u> to <u>Jan. 26, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25, 1962</u> , and that death occurred at <u>4 A.M.</u> from <u>the causes and on the date stated above.</u>					
22a. SIGNATURE <u>Robert A. Hare</u>			22b. DATE SIGNED <u>1/26/62</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare, M.D.</u>			22d. ADDRESS <u>7600 Carroll Ave, T. Pk, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>			23b. DATE THEREOF <u>Jan 30, 1962</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>Chesterwood</u>			23d. LOCATION (City, town or county) (State) <u>Chesterwood, Maryland</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler</u>			25a. REC'D BY REGISTRAR <u>James H. Butler</u>		
25b. REGISTRAR'S SIGNATURE <u>James H. Butler</u>			25c. DATE <u>JAN 31 '62</u>		

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers nos 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be completed by the hospital or attending physician. Part 2 may be completed by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Parts 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Parts 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00766  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2314 Colston Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>2314 Colston Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Cephas Edgar Bittinger</u> First Middle Last 4. DATE OF DEATH <u>January 30 1962</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 13, 1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Internal Rev.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Chambersburg, Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Bittinger</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>World War I</u> 17. INFORMANT <u>Inez P. Bittinger</u> Address <u>2314 Colston Dr. Sil Sp Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Broncho-Pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>Jan 28, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 28, 1962</u> and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Joseph H. Watson</u> M.D. 22b. DATE SIGNED <u>Jan 29, 1962</u> 22c. PHYSICIAN'S NAME (Type) 22d. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-1-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem</u> 23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Deal Funeral Home</u> ADDRESS <u>4812 Ga. Ave., N.W., Wash. DC</u> 25a. REC'D BY REGISTRAR <u>FEB 1 1962</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Ramey</u>			



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1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00767

00261

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>4 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1258 Cresthaven Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Herman</u> Middle <u>NMN</u> Last <u>Blankenburg</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-12-96</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>
12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>		13. FATHER'S NAME <u>Gotthard Blankenburg</u>	
14. MOTHER'S MAIDEN NAME <u>Alwine Joch</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>579-32-7865</u>		17. INFORMANT <u>Hospital Records</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac Failure</u> <u>502-0</u> DUE TO (b) <u>Chronic Pulmonary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Chronic Bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 25</u> ..... 19 <u>57</u> to <u>Jan. 23</u> ..... 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>Dec. 29</u> ..... 19 <u>61</u> ..... and that death occurred at <u>7:20</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>J. Keithrop Peabody Sr.</u> M.D.		22b. DATE SIGNED <u>1/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>1746 K. ST. N.W. WASH. DC</u>		22d. ADDRESS <u>1746 K. ST. N.W. WASH. DC</u>	
23a. BURIAL, CREMATION, REBURY (Specify)		23b. DATE THEREOF <u>Jan. 27, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		23d. LOCATION (City, town or county) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. - Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>Jan 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>	



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

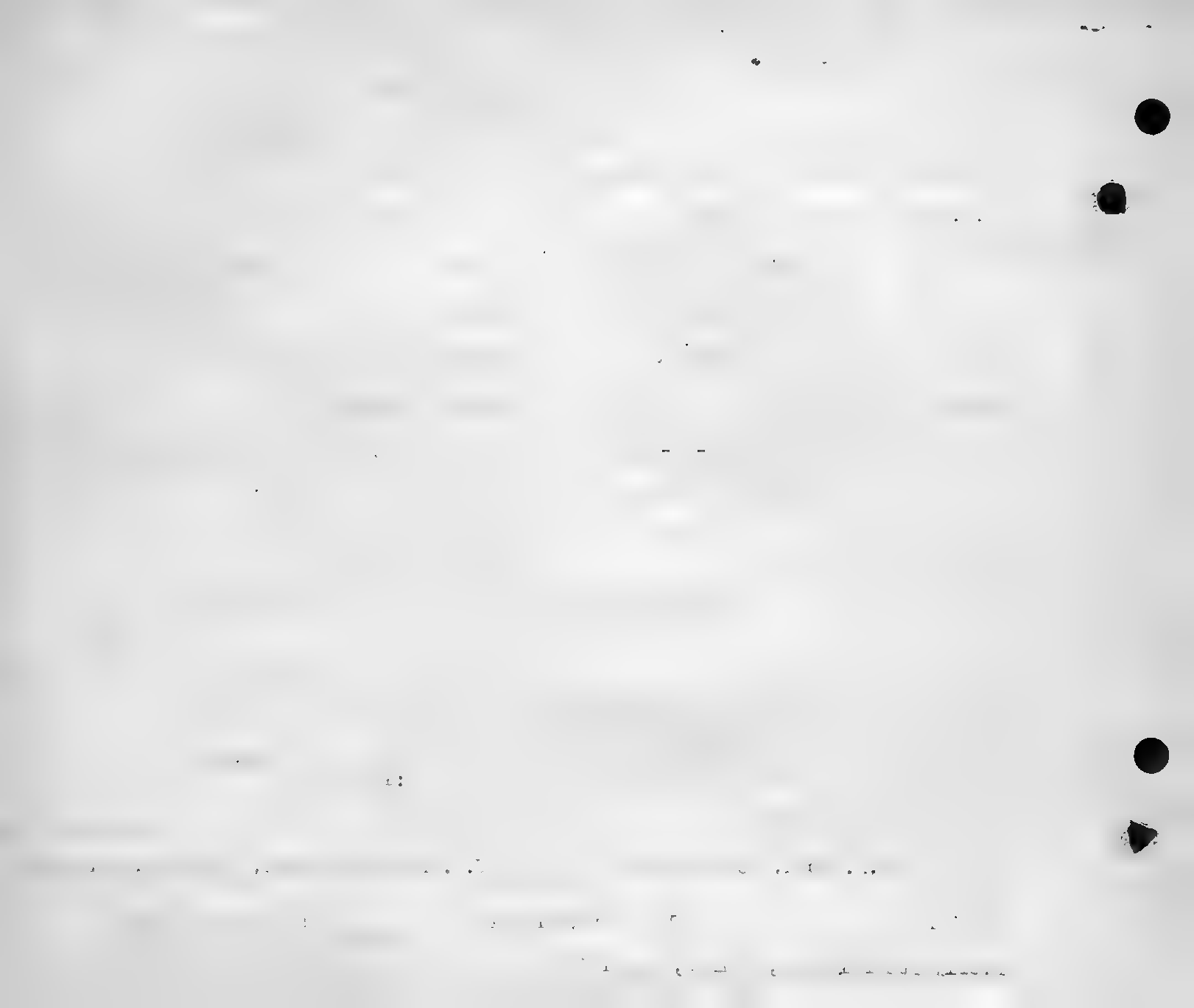
CERTIFICATE OF DEATH

00768

00762

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Bethesda</b> <b>15 minutes</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, NNMC</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairfax</b> d. STREET ADDRESS <b>20 Norman Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>Goerge Oliver Botts</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>20</b> Year <b>1962</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>Cau</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>28 April 1909</b>	<b>9. AGE</b> (In years last birthday) <b>52 yrs.</b>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>USN Lawyer</b>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>USN</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lawyer</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Pennsylvania</b>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>George R. Botts</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Maggie Broschious</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>225-52-5362</b>		<b>17. INFORMANT</b> <b>Wife-Christine M. Botts, 20 Norman Ave., Fairfax, Va.</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420</b> <b>Due to</b> <b>420</b> <b>ASHD</b> <b>6 yrs</b> Conditions, if any, which gave rise to immediate cause (b) <b>420</b> <b>Due to</b> <b>420</b> <b>ASHD</b> <b>6 yrs</b> (c), stating the underlying cause last. <b>420</b> <b>Due to</b> <b>420</b> <b>ASHD</b> <b>6 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420</b> <b>Due to</b> <b>420</b> <b>ASHD</b> <b>6 yrs</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> <b>20d. INJURY OCCURRED</b> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>20 January 1962</b> , to <b>20 January 1962</b> that <b>(H)</b> (we) last saw the deceased alive on <b>20 January 1962</b> , and that death occurred at <b>7:15 AM</b> the causes and on the date stated above. <b>22a. SIGNATURE</b> <b>22b. DATE SIGNED</b> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>V.N. Houk, LCDR MC USN</b> <b>22d. ADDRESS</b> <b>U.S. Naval Hospital, Bethesda, Maryland</b>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1-23-62</b>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Arlington National</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Arlington, Virginia</b>		
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Everly Funeral Home, Fairfax, Virginia</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>JAN 23 '62</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be signed by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00769  
00769

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b. <u>1 1/2</u> days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9408 Wire Ave</u>	
3. NAME OF DECEASED (Type or print) <u>John William Bowles</u> First Middle Last 4. DATE OF DEATH <u>Jan 1 1962</u> Month Year Day		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-24-04</u> 9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Sheet Metal Company</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u> 12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>Warner Bowles</u> 14. MOTHER'S MAIDEN NAME <u>Emma Bowles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>578-03-3216</u> 17. INFORMANT <u>Pt chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } (b) <u>Branchogenic carcinoma</u> (c) <u>Arteriosclerotic Heart Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>2 1/2 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1954</u> to <u>Jan 1, 1962</u> , that (I) <u>never</u> last saw the deceased alive on <u>Jan 1</u> , 19 <u>62</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Seruch T. Kimble</u> 22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble, M.D.</u>		22b. DATE SIGNED <u>1-1-62</u> 22d. ADDRESS <u>937 Piershing Drive, Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-4-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Silver Spring Maryland</u>		25a. REC'D BY REGISTRAR <u>W.E. Humphrey Inc</u> 25b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u> DATE <u>JAN 4 '62</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00770

00764

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (For cities of corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>11/6/61 to 1/19/62</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1311 Madison St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Katharine E. Bowman</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>January 19 1962</u>	
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10/30/1884</u>	
<b>9. AGE</b> (In years last b'd'ay) <u>77</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Library of Congress U.S. Govt.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>New Jersey</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>George Bowman</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Louisa P. Cook</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) _____		<b>16. SOCIAL SECURITY NO.</b> (If yes give war or dates of service) _____	
<b>17. INFORMANT</b> <u>Sanitarium Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 Hours</u> <u>4 Hours</u> <u>2 YRS</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour a.m. _____ p.m. _____ Month, Day, Year <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> (County) (State) _____	
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>Feb 1, 1949</u> <b>to</b> <u>Jan 19, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 17, 1961</u> , <b>and that death occurred at</b> <u>6:45 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Horace H Custis Jr</u>		<b>22b. DATE SIGNED</b> <u>1/19/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>HORACE H CUSTIS JR</u>		<b>22d. ADDRESS</b> <u>1852 Columbia Rd NW WASH DC</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>1/23/62</u>		<b>23b. DATE THEREOF</b> _____	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Washington, D.C.</u> <u>DC</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co., 2901 14th St. N.W. Wash</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 22 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. W. S. Hines</u>		<b>25c. REGISTRAR'S SIGNATURE</b> _____	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





00771

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Olney</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 19</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		d. STREET ADDRESS <u>901 Prospect Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Wallace</u> Last <u>Boyd</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1962</u>	
5. SEX <u>f</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30 1881</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wilkerson Wallace</u>		14. MOTHER'S MAIDEN NAME <u>Martha Kelly</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Frances Boyd</u>		Address <u>Chry Chase 9nd 2602 Spencer Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>8-10</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>mid July</u> , 19 <u>61</u> , to <u>1/1/62</u> , that I last saw the deceased alive on <u>12/31</u> , 19 <u>61</u> , and that death occurred at <u>5:45</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Sandy Spring, Maryland</u> DATE SIGNED <u>1/1/62</u> ACTUAL SIGNATURE <u>John P. Martin, M.D.</u> PHYSICIAN'S NAME (Type) <u>John P. Martin, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond G. Ziska</u>		ADDRESS <u>Silver Spring, Md.</u>	24a. REC'D BY REGISTRAR <u>Jan 4 '62</u>
24b. REGISTRAR'S SIGNATURE <u>William L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00772

CERTIFICATE OF DEATH

00766

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring  
c. LENGTH OF STAY IN 3 years  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11,504 Lovejoy Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring  
d. STREET ADDRESS 11,504 Lovejoy Street  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) Mary Agnes Braun

4. DATE OF DEATH January 24 19 62

5. SEX female 6. COLOR OR RACE white 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
8. DATE OF BIRTH Dec. 30, 1890 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS: Hours 0 Min. 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own home 11. BIRTHPLACE (County & State, or foreign country) Kentucky 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Unclebach 14. MOTHER'S MAIDEN NAME Agnes Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? NO 16. SOCIAL SECURITY NO. 404-36-5799 17. INFORMANT Robert F. Wilbert Address 11,504 Lovejoy St. Silver Spring, Md.

18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 423.1 DUE TO MYOCARDIAL INFARCTION  
Conditions, if any, which gave rise to immediate cause (b) ARTERIO SCLEROTIC HEART DIS.  
(c) HYPERTENSION  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 9 HOURS  
(b) 10 YEARS  
(c) 10 YEARS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18, OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER))  
20c. TIME OF INJURY Month, Day, Year 19 62 20d. INJURY OCCURRED While at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1124 20f. (City or town, (County) (State) 1124 19 62 1124

21. I certify that (I) (this hospital) attended the deceased from 1124 to 1124, 1962 that (I) 1124 saw the deceased alive on 1124, 1962, and that death occurred at 8:00 AM, from the causes and on the date stated above.  
22a. SIGNATURE David Goldenberg M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22b. DATE SIGNED 1/25/62  
22c. PHYSICIAN'S NAME (Type) David Goldenberg 22d. ADDRESS 10,620 Georgia Ave. Silver Spring, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-27-62 23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven 23d. LOCATION (City, town or county) (State) Montgomery Maryland

24. FUNERAL DIRECTOR'S SIGNATURE Warner E. Pumphrey, Inc. ADDRESS Georgia Ave. Silver Spring, Md. 25a. REC'D BY REGISTRAR JAN 29 1962 25b. REGISTRAR'S SIGNATURE John E. Haines

Coroner notified and approved

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

00267

00773

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>...</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>7504 Jackson Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mr. John Aloysius Breen</b>		4. DATE OF DEATH <b>January 1, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. UNDER 1 YEAR Months <b>...</b> Days <b>...</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Govt Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>District of Columbia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Breen</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Droney</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>...</b>	
17. INFORMANT <b>Washington Sanitarium and Hospital Records</b>		Address <b>...</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>261X Congestive Heart Failure</b> DUE TO (b) <b>Bilateral pulmonary atelectasis with hydrothorax</b> DUE TO (c) <b>Diabetes, Cirrhosis of the liver.</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>...</b> p.m. <b>...</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>August, 1961</b> to <b>January 1, 1962</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 31, 1961</b> , and that death occurred at <b>5:09 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Belden R. Reap</b>		22b. DATE SIGNED <b>JAN. 1, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP</b>		22d. ADDRESS <b>WHEATON, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Georg Washington Cemetery</b>		23d. LOCATION City, town, or county (State) <b>Adelphi, Pr. Geo. Co. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>		25c. REGISTRAR'S SIGNATURE <b>Arthur Walters</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

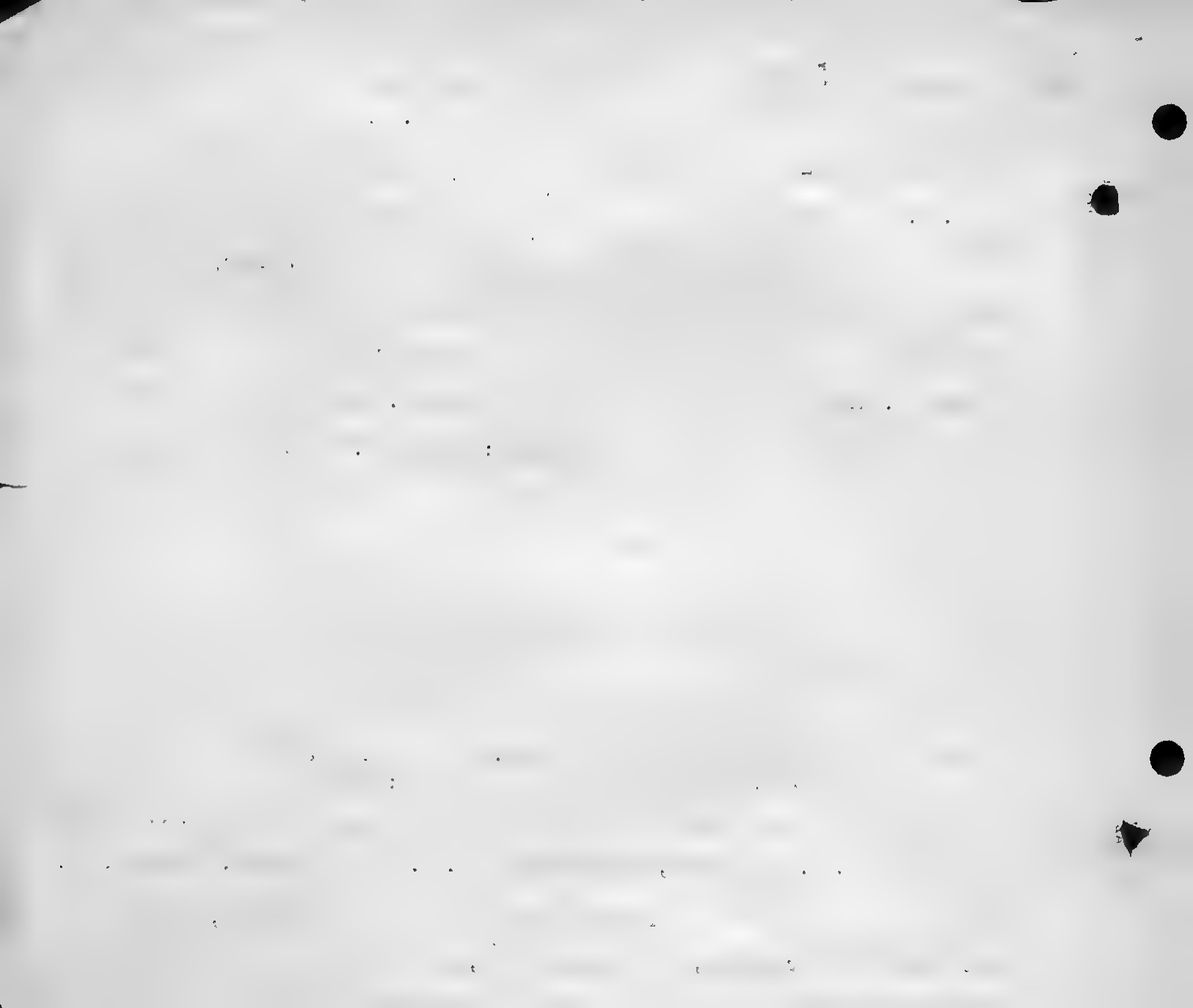


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>12 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
f. STREET ADDRESS <b>5510 39th Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Alice Reed Bried</b>		4. DATE OF DEATH Month Day Year <b>January 8, 19 62</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <b>January 11, 1923</b>		9. AGE (In years last birthday) <b>38</b>		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Thomas G. Reid</b>		14. MOTHER'S MAIDEN NAME <b>Ellen F. Sullivan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FATHER: Thomas G. Reid, Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic coma</b> DUE TO (b) <b>Laennec's Cirrhosis</b> DUE TO (c) <b>Diabetic Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>Dec 28</b> , 19 <b>61</b> , to <b>Jan 8</b> , 19 <b>62</b> that (2) (we) last saw the deceased alive on <b>Jan 8</b> , 19 <b>62</b> and that death occurred at <b>10:55 PM</b> on the causes and on the date stated above.					
22a. SIGNATURE <b>P. G. Linaweaver</b>		22b. DATE SIGNED <b>January 9, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>P. G. LINAWEAVER, LCDR MC USN</b>	
22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>1-12-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Timothy Hanlon</b>		24a. ADDRESS <b>WDC</b>		24b. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
24c. REG STRAR'S SIGNATURE <b>Charles S. Hanna</b>		24d. REG STRAR'S SIGNATURE			





TO HOSPITAL OR A MOUNTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and send page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00775

Item 23b, Film G306 2/6/62 iwk

00769

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Florida</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Bethesda</b>		b. COUNTY <b>Green Cove Springs</b>	
c. LENGTH OF STAY IN 1b <b>4 days</b>		d. STREET ADDRESS <b>Orangedale Route</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Kevin Lowell BROADWATER</b>		4. DATE OF DEATH <b>January 29 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1961</b>
9. AGE (in years last birthday) <b>2 yrs.</b>		10. AGE (in years last birthday) <b>2 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>No</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Kingsport, Tenn.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lowell Howard BROADWATER</b>		14. MOTHER'S MAIDEN NAME <b>Margaret KILGORE</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(Mother) Margaret Broadwater, Nickelsville, Va.</b>	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Conventional Heart Disease Pulmonary Atresia</b> <b>754.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, } DUE TO PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>INTERVAL BETWEEN ONSET AND DEATH 10 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>25 January 1962</b> to <b>29 January 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>29 January 1962</b> , and that death occurred <b>4:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>James L. Beeby</b>		22b. DATE SIGNED <b>Jan. 30, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES L. BEEBY LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Nickelsville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Nickelsville, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphery Funeral Home</b>		25a. REC'D BY REGISTRAR <b>FEE 1 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		DATE	



TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00776

00770

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>14 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8118 Chester st. 1</u>	
3. NAME OF DECEASED (Type or print) <u>George Irwin Burnesten</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-1-95</u> 9. AGE (in years last birthday) <u>16</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> IF UNDER 24 HRS: Hours <u>1</u> Min. <u>5</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> 11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George H. Burnesten</u> 14. MOTHER'S MAIDEN NAME <u>Hall</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Hosp. Records</u> 16. SOCIAL SECURITY NO. <u>1-1-1-1</u> 17. INFORMANT <u>Hall</u> Address <u>Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>Chronic Bronchitis</u> DUE TO <u>Chronic Bronchitis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 hrs</u> <u>10 1/2 hrs</u> <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/62</u> to <u>1/5/62</u> , that (I) (we) last saw the deceased alive on <u>1/5/62</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward T. Morse</u> 22c. PHYSICIAN'S NAME (Type) <u>Edward T. Morse M.D.</u>		22b. DATE SIGNED <u>1/5/62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>7030 Carver Ave Takoma Park Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-8-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Dean Funeral Home</u>		25a. REC'D BY REGISTRAR <u>8</u> 25b. REGISTRAR'S SIGNATURE <u>C. S. S. S.</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00777

00777

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Martinsburg</u> <u>85X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>				d. STREET ADDRESS <u>Rt. 1 Box 97W.</u> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Florence Belle Carpenter</u> First Middle Last				4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1962</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 Dec 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jasper S. G. Ibert</u>				14. MOTHER'S MAIDEN NAME <u>Maria Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Charles W. Carpenter-Husband-same 2d</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypostatic pneumonia</u> <u>450</u> DUE TO (b) <u>Senile mental deterioration with paranoia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <u>Arteriosclerosis</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 2, 1948</u> to <u>Jan. 16, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 16, 1962</u> and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Katharine A. Chapman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 16, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Katharine A. Chapman</u>				22d. ADDRESS <u>3924 Balto. Ave. Kensington, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/19/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS				25a. REC'D BY REGISTRAR <u>JAN 19 62</u>		25b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate should be filled in by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9 60

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00778

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00778

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
f. STREET ADDRESS <u>1403 Crabbe Ave</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Leonard Frank Caudell, Jr.</u>		4. DATE OF DEATH <u>Jan 20 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-18-1927</u>	
9. AGE (In years last birthday) <u>34 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Leonard Caudell</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Richardson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>246-283-788</u>	
17. INFORMANT <u>Betty Caudell (wife)</u>		Address <u>Stim 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>Hemorrhage into Atheromatous Plaque</u> DUE TO (c) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschiant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschiant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/24/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR <u>Sydney Wheeler</u>		24. REGISTRAR'S SIGNATURE <u>William S. Kline</u>	
25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>		25b. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be prepared by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN b. 77 days		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE Nebraska		b. COUNTY Lincoln		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 7001 Pioneer Boulevard		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Sylvia Ruth Christensen		4. DATE OF DEATH January 23, 1962		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 August 1914		9. AGE (in years, if UNDER 1 YEAR, last birthday) 47 yrs		10. IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (County & State, or foreign country) Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Mortensen		14. MOTHER'S MAIDEN NAME Pearl Foster		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available		17. INFORMANT The Medical Record, Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 204.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Sepsis with metastatic abscesses Acute myelogenous leukemia Bronchopneumonia and pulmonary hemorrhage and edema		INTERVAL BETWEEN ONSET AND DEATH 3 days 7 months 3 days		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adrenal hemorrhage.. Thyroid nodule		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. TIME OF INJURY Hour a.m. p.m. 19		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) Lincoln		20e. (County) Nebraska		20f. (State) Nebraska	
21. I certify that (X) (this hospital) attended the deceased from November 7, 1961 to January 23, 1962 that (H) (we) last saw the deceased alive on January 23, 1962, and that death occurred at 8:15 A.M. from the causes and on the date stated above		22a. SIGNATURE J. David Heywood		22b. DATE SIGNED January 23, 1962		22c. PHYSICIAN'S NAME (Type) J. David Heywood		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit 1/23/62		23b. DATE THEREOF 1/23/62		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem. Park		23d. LOCATION (City, town or county) Lincoln, Nebraska		23e. (State) Nebraska	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR JAN 26 '62		25b. REGISTRAR'S SIGNATURE C. J. H. H. H.		25c. ADDRESS		25d. CITY OR TOWN		25e. COUNTY		25f. STATE		25g. ZIP CODE		25h. OTHER		25i. OTHER	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00780

00774

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aldie</u>		83 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Sanatorium</u>		d. STREET ADDRESS <u>"Chudleigh Farm"</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William H Clifford</u>		4. DATE OF DEATH Month Day Year <u>1 25 1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 July 1875</u>
9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>US Army</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Clifford</u>		14. MOTHER'S MAIDEN NAME <u>Mabel M. Moore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>SpAm - WWII</u>		16. SOCIAL SECURITY NO	
17. INFORMANT Address <u>Wm. H. Clifford Jr. Fairfax Hotel</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic carcinoma</u> <u>Aortic Stenosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Jan 1962</u> that (I) <u>last</u> saw the deceased alive on <u>1/21</u> 19 <u>62</u> and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above			
22a. SIGNATURE <u>Robert F. Dyer</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert F. Dyer MD</u>		22d. ADDRESS <u>915 19th St NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>26 Jan 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 29 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Fraser</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00781

CERTIFICATE OF DEATH

Item 2 Film G306 2/9/62 iwk

04775

1. PLACE OF DEATH

a. COUNTY **Montgomery**

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

**Olney**

c. LENGTH OF STAY IN b

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

**Olney Sharon Nursing Home**

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

**Montgomery General Hospital**

d. STREET ADDRESS

**Dominion Drive**

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

First

Middle

**M.**

**Cole**

4. DATE OF DEATH

Month

Day

Year

**Jan.**

**36**

**62**

5. SEX

**female**

6. COLOR OR RACE

**white**

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

**12/17/1878**

9. AGE (In years last birthday)

**83**

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

**Housewife**

10b. KIND OF BUSINESS OR INDUSTRY

**Home**

11. BIRTH PLACE (Country & State, or foreign country)

**Pa.**

12. CITIZEN OF WHAT COUNTRY?

**U.S.**

13. FATHER'S NAME

**James Meek**

14. MOTHER'S MAIDEN NAME

**Henrietta Carpenter**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

**no**

16. SOCIAL SECURITY NO.

**Unknown**

17. INFORMANT

**Hospital Records**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)

INTERVAL BETWEEN ONSET AND DEATH

**4 days**

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18)

20c. TIME OF INJURY

Month, Day, Year

20d. INJURY OCCURRED

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)

20f. (City or town)

(County)

(State)

Hour a.m. p.m.

**19**

While at work ☐

Not While at work ☐

21. I certify that (I) (this hospital) attended the deceased from **Jan. 27, 1962** to **Jan. 27, 1962** that (I) (we) last saw the deceased alive on **Jan. 29, 1962**, and that death occurred at **1:12 AM**, from the causes and on the date stated above.

22a. SIGNATURE

22c. PHYSICIAN'S NAME (Type)

**Joseph E. Smith, Jr.**

M.D.

ATTENDING PHYS.

MED. DIRECTOR ☐

STAFF PHYS. ☐

22d. ADDRESS

**101 Indian Spr. Dr. Silver Spring, Md.**

22b. DATE SIGNED

**Jan. 30, 1962**

23a. BURIAL, CREMATION, REMOVAL (Specify)

**Burial**

23b. DATE THEREOF

**Feb. 1, 1962**

23c. NAME OF CEMETERY OR CREMATORY

**Ft. Lincoln**

23d. LOCATION (City, town or county)

**Washington, D. C.**

(State)

24. FUNERAL DIRECTOR'S SIGNATURE

**Francis H. Barber**

ADDRESS

**Laytonsville, Md.**

25a. REC'D BY REGISTRAR

DATE **FEB 1 '62**

25b. REGISTRAR'S SIGNATURE

**Arthur L. Hines**

OF

7

6 5

6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00782

00776

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>3915 Joliet Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3915 Joliet Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BESSIE CONNELL</u>				4. DATE OF DEATH <u>January 13, 1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 25, 1889</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Aaron Marcus (Deceased)</u>				14. MOTHER'S MAIDEN NAME <u>Sarah (Deceased)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-03-2525</u>			
17. INFORMANT <u>Harry Reiness 13411 Dauphine St, Wheaton, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Arteriosclerosis</u> (c) <u>Coronary Arteriosclerosis</u> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Has had several coronary occlusions in the past. Essential Hypertension. Generalized Arteriosclerosis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1961</u> to <u>Jan. 13, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec. 15, 1961</u> and that death occurred at <u>3:00 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Berttram F. Schaefer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Jan. 13, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Berttram F. Schaefer</u>				22d. ADDRESS <u>1780 Massachusetts Ave. N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Jan 15, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nat'l. Mem. Park</u>	
23d. LOCATION (City, town or county) (State) <u>Falls Church, Va.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 9th Street N.W., DC</u>		25a. REC'D BY REGISTRAR <u>JAN 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Person may be buried by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 .4,  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00783

Items 23 Film G200 2/2/62 iwk

01777

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>13 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital,</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1826 Vernon Street, Apt. 47X</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Frederick (n) Cook</b>			4. DATE OF DEATH <b>January 29, 19 62</b>		
5. SEX <b>Male</b> 6. COLOR OR RACE <b>Negroid</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 5, 1890</b> 9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Frederick Cook</b> 14. MOTHER'S MAIDEN NAME <b>Lee Alexander</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Lee Alexander</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>446X</b> DUE TO <b>Nephrosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) <b>unknown</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (this hospital) attended the deceased from <b>Jan. 16, 1962</b> to <b>Jan. 29, 1962</b> , that (we) last saw the deceased alive on <b>Jan. 29, 1962</b> , and that death occurred at <b>7:35 PM</b> on the causes and on the date stated above					
22a. SIGNATURE <b>William P. Baker</b> 22b. DATE SIGNED <b>Jan. 30, 1962</b>			22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. BAKER LT MC USN</b>		
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2.3.62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM. PARK</b> 23d. STATE <b>MARYLAND</b> (State) <b>Arlington, VA</b>			24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert G. McGuire</b> 25a. REC'D BY REGISTRAR <b>Feb 2 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00784

Item 23b, Film 6505 2/1/62 iwk

04778

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>1 day</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3226 9th Street</b> d. STREET ADDRESS <b>3226 9th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OMAR WILSON COOPER</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 13 19 62</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUC</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>31 MARCH 1917</b> 9. AGE (In years last birthday) <b>44 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S.. NAVY Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ky.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ky.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS COOPER</b>		14. MOTHER'S MAIDEN NAME <b>LILLIE BURDEN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>HOSPITAL RECORDS</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis, Bilateral, severe</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Bacteremia</b> (c) <b>Fatty metamorphosis of Liver</b> DUE TO (e), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 12 1962</b> , to <b>Jan. 13 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 13 1962</b> , and that death occurred at <b>1417</b> M, from the causes and on the date stated above.			
21a. SIGNATURE <b>James M. Brown LCDR MC USN</b>		21b. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <b>13 Jan 1962</b>	
21c. PHYSICIAN'S NAME (Type) <b>JAMES M. BROWN LCDR MC USN</b>		22a. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 18, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Maysville Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Maysville Kentucky</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert S. Murphy</b>		25a. REC'D BY REGISTRAR <b>JAN 18 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		25c. REGISTRAR'S SIGNATURE	

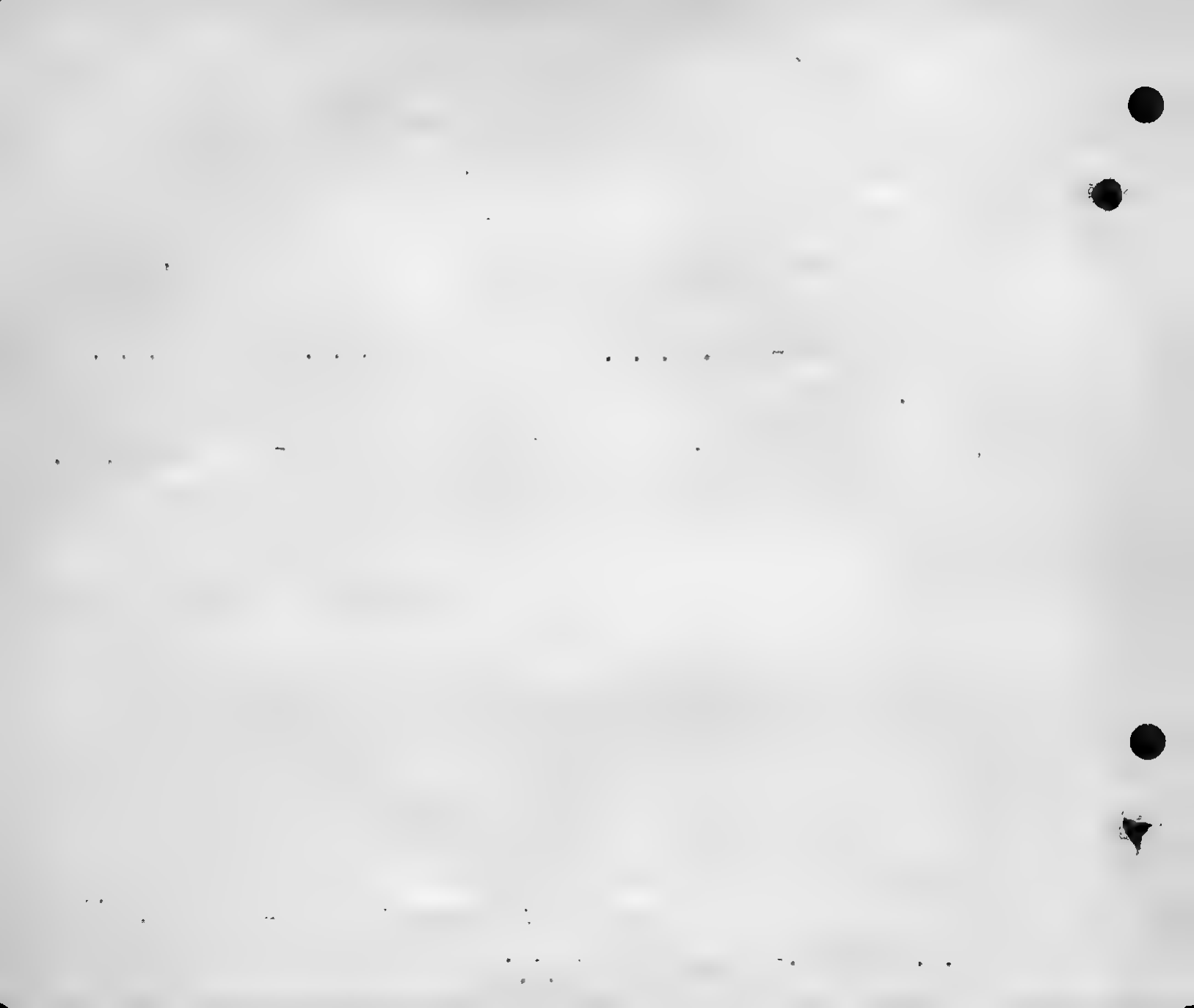


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00785  
00779  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN b.  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4415 Bradley Lane</b>		2. USUAL RESIDENCE (Where deceased lived, if inst. full-time; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4415 Bradley Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jerome Bradshaw Cowden</b>		4. DATE OF DEATH <b>January 15, 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/5/1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Government Work - Supt. G.P.O.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington, D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frank B. Cowden</b>	
14. MOTHER'S MAIDEN NAME <b>Louise Bradshaw</b>		15. WAS DECEASED EVER IN U.S.A. ARMED FORCES? <b>yes</b>	
16. SOCIAL SECURITY NO. <b>WWII</b>		17. INFORMANT <b>Mignon Smith Cowden</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> Conditions, if any, which gave rise to immediate cause (b) <b>Cardiac Failure</b> (a), stating the underlying cause last. (c) <b>Auricular Fibrillation</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>15 Min.</b> <b>4 hours</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a) <b>Aneurysm Left Iliac Artery</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 1945</b> to <b>Jan 15, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 15, 1962</b> and that death occurred at <b>2:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Bradley D. Hodgkins MD</b>		22b. DATE SIGNED <b>Jan 18, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BRADLEY D. HODGKINS</b>		22d. ADDRESS <b>4413 Bradley Lane Chevy Chase Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/18/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>National Capitol Memorial Park - Muirkirk, Maryland</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co. - 2901 14th St., N.W.</b>		25a. REGISTERED BY REGISTRAR <b>JAN 18 1962</b>	
ADDRESS <b>Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR AFTER DEATH. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 '4)  
15M 7 61

MAY 1962											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00786 Item 23b, Film 6305 1/12/62 ink 00786											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN b. <b>2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>											
3. NAME OF DECEASED (Type or print) <b>Elizabeth Holland Cox</b>				4. DATE OF DEATH <b>January 19, 1962</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Female</b>				6. COLOR OR RACE <b>Caucasian</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>Blue Springs, Mississippi</b>			
13. FATHER'S NAME <b>William H. Smith</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Rhea</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>- - - -</b>				17. INFORMANT <b>Husband: Max Cox, Same as #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Myocardial infarction, recent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <b>Jan. 8, 1962</b>				20d. INJURY OCCURRED <b>While at work</b>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <b>Arlington</b>				20g. (County) <b>Arlington</b>				20h. (State) <b>Virginia</b>			
21. I certify that (this hospital) attended the deceased from <b>Jan. 8, 1962</b> to <b>Jan. 10, 1962</b> that (we) last saw the deceased alive on <b>Jan. 10, 1962</b> , and that death occurred at <b>6:05 AM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>V. N. HOUK, LCDR MC USN</b>				22b. DATE SIGNED <b>January 10, 1962</b>							
22c. PHYSICIAN'S NAME (Type) <b>V. N. HOUK, LCDR MC USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>							
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 12, 1962</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town or county) <b>Arlington</b>				23e. (State) <b>Virginia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Sange</b>				24b. ADDRESS <b>Ives Funeral Home, 2847 Wilson Blvd., Arlington, Va.</b>				25a. REC'D BY REGISTRAR <b>JAN 12 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles S. Sange</b>											





TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
(M)

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00787

00781

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood R.F.D.#1</u> c. LENGTH OF STAY IN b. <u>5 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ammons Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>419 Carrollton Drive</u> d. STREET ADDRESS <u>Frederick, Md</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ammons Nursing Home</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Mary Col</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Craddock</u> <b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Virginia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>4. DATE OF DEATH</b> <u>January 16, 1962</u> Month Day Year <b>8. DATE OF BIRTH</b> <u>4-23-1876</u> Yrs. Months Days Hours Min. <b>9. AGE</b> (In years last birthday) <u>85</u> IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
<b>13. FATHER'S NAME</b> <u>Albert Woodley</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Alice (Unknown)</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>Nursing Home Records</u> <b>17. INFORMANT</b> <u>Address</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u> <u>4222</u> DUE TO (b) <u>Chronic Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) <u>5 years</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b> <u>Frederick, Md</u>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>November 14, 1961</u> <b>to</b> <u>January 16, 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>January 14, 1962</u> <b>and that death occurred at</b> <u>5:30 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>James L. Leal</u> M.D. <b>22c. PHYSICIAN'S NAME (Type)</b> <u>James L. Leal</u>		<b>22b. DATE SIGNED</b> <u>Jan 16, 1962</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>214 E. 1st St. Frederick, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1-19-62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Hopehill</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Hopehill Frederick, Co Md</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>C.E. Hicks III</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 22 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>W. S. Hume</u>			



## CERTIFICATE OF DEATH

00788

00282

**1. PLACE OF DEATH**  
a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN b 10 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SUBURBAN

**2. USUAL RESIDENCE** (Where deceased lived, if institution; Residence before admission)  
a. STATE MARYLAND b. COUNTY D.C.  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON  
d. STREET ADDRESS 2770 BELMONT ROAD N.W.

**3. NAME OF DECEASED** (Type or print) LOUISE C CURTIS  
First Middle Last  
**4. DATE OF DEATH** JAN. 28 1962  
Month Day Year  
**5. SEX** Female **6. COLOR OR RACE** White **7. MARRIED** ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐  
**8. DATE OF BIRTH** 9/23/03  
**9. AGE** (In years last birthday) 58 yrs. **IF UNDER 1 YEAR** Months Days **IF UNDER 24 HRS.** Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Correspondence Officer **10b. KIND OF BUSINESS OR INDUSTRY** State Dept. **11. BIRTHPLACE** (County & State, or foreign country) Penn. U.S.A. **12. CITIZEN OF WHAT COUNTRY**

**13. FATHER'S NAME** Jerome J. Casey **14. MOTHER'S MAIDEN NAME** Mary Halpine  
**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give year or dates of service) No **16. SOCIAL SECURITY NO.** None **17. INFORMANT** Son C. Alexander Curtis  
**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b) and (c)]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (e) Septicemia  
Bacterial endocarditis  
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)  
**20c. TIME OF INJURY** Month, Day, Year Hour a.m. p.m. 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** County (State)

**21. I certify that (I) (this hospita.) attended the deceased from Jan. 18, 1962 to Jan. 28, 1962 that (I) (we) last saw the deceased alive on Jan. 28, 1962, and that death occurred at 6:15 A.M. from the causes and on the date stated above**  
**22a. SIGNATURE** LEO P. PUMPHREY M.D. **ATTENDING PHYS.** ☒ **MED. DIRECTOR** ☐ **STAFF PHYS.** ☐ **DATE SIGNED** 1/29/62  
**22c. PHYSICIAN'S NAME** (Type) LEO P. PUMPHREY **22d. ADDRESS** 8218 WILSON AVE BETHESDA MD

**23a. BURIAL, CREMATION, REMOVAL** (Specify) Burial-transit 1-29-62 **23b. DATE THEREOF** 1-29-62 **23c. NAME OF CEMETERY OR CREMATORY** Cathedral Cemetery **23d. LOCATION** (City, town or county) Scranton, Penna. (State)

**24. FUNERAL DIRECTOR'S SIGNATURE** ROBERT A. PUMPHREY **ADDRESS** Bethesda, Md. **25a. REC'D BY REGISTRAR** **25b. REGISTRAR'S SIGNATURE** Arthur E. Hunter  
**DATE** FEB 1'62

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00789

00783

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		
c. LENGTH OF STAY IN <b>5 days</b>			d. STREET ADDRESS <b>108 Normandy Drive</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Resmor Sanitarium</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Nora</b> Middle <b>N</b> Last <b>Curtis</b>			4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> Year <b>19 62</b>		
5. SEX <b>Female</b>			6. COLOR OR RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>3/4/1881</b>		
9. AGE (In years last birthday) <b>80</b> yrs.			10. IF UNDER 1 YEAR Months <b>10</b> Days <b>20</b> Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Andy Shiflett</b>			14. MOTHER'S MAIDEN NAME <b>Catherine Snow</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		
17. INFORMANT <b>Son-Earl W. Shiflett-same 2d</b>			Address <b>-----</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of cervix with metastases</b> DUE TO <b>171X</b> Conditions, if any, which gave rise to immediate cause (b) <b>-----</b> DUE TO <b>-----</b> (c) <b>-----</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>-----</b> (b) <b>-----</b> (c) <b>-----</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Hour <b>a.m.</b> <b>19</b> p.m. <b>-----</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b>		20g. (County) <b>-----</b>		20h. (State) <b>-----</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 12, 1961</b> to <b>Jan. 24, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 24, 1962</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Katharine A. Chapman</b>			22b. DATE SIGNED <b>Jan. 24, 1962</b>		
22c. PHYSICIAN'S NAME (Type) <b>Katharine A. Chapman</b>			22d. ADDRESS <b>3924 Baltimore Rd. Kensington, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 1/25/62</b>		23b. DATE THEREOF <b>1/25/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Roseland Park Cem.</b>	
23d. LOCATION (City, town or county) <b>Royal Oak, Michigan</b>		23e. REC'D BY REGISTRAR <b>-----</b>		23f. REGISTRAR'S SIGNATURE <b>-----</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn &amp; Hosp</u>		d. STREET ADDRESS <u>2011 HANNON ST</u>	
3. NAME OF DECEASED (Type or print) <u>Louis Peter Demas</u>		4. DATE OF DEATH Month <u>1</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant Retired Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Demas</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>William Demas, 2011 Hannon St., Lewisdale Md.</u>		Address <u>                    </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>                    </u> DUE TO <u>                    </u> (c) <u>                    </u> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>months</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>                    </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>		20f. (City or town) <u>                    </u> (County) <u>                    </u> (State) <u>                    </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>Jan 26, 62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) <u>Pr. Geo. Co., Maryland</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co., 2901 14th St. N.W., Wash, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 26 1962</u>	
24b. REGISTRAR'S SIGNATURE <u>                    </u>		DATE <u>                    </u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be called by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00792

00786

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN It <u>3mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District Heights</u> d. STREET ADDRESS <u>3400 Senator Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Maude Evans</u> First Middle Last 5. SEX <u>f</u> 6. CO. OR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 4 1873</u> 9. AGE (In years last birthday) <u>88</u> yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours M. n.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N York</u>	
13. FATHER'S NAME <u>John Hamilton</u>		14. MOTHER'S M.A.D.E.N NAME <u>Esther Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> (Yes, no, or unknown) (If yes give war and dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miniam Hanley</u> Address <u>3400 Senator Ave Wash 28</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (b) <u>Intermittent Cardiac Disease</u> (a), stating the underlying cause last (c) <u>Disease</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF CONTRIBUTING CAUSE OF DEATH (If either NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day, Year <u>Hour</u> <u>19</u> <u>p.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/8</u> to <u>1/16/62</u> and that death occurred at <u>6:30 pm</u> on the date stated above.			
22a. SIGNATURE <u>John P. Martin</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/16/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City, town or county) (State) <u>Hampstead New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Arthur E. Hays</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>JAN 17 '62</u>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00793

011787

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) o STATE <u>MD</u> b. COUNTY <u>Mont</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joshua George Dosh</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>24</u> Year <u>1962</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 14, 1913</u>	9. AGE (In years last birthday) <u>48</u> yrs	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS Hours _____ Min. _____	
10a. USLA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic Plane Aircraft</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Dosh</u>				14. MOTHER'S MAIDEN NAME <u>Eva Pheasant</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO _____		17. INFORMANT Address <u>MRS. J. Dosh 305 Ritchie Pkwy</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH <u>minute</u>
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>							
420.0 DUE TO (b) <u>Arteriosclerotic H. D.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		
			20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>1/24</u> , 1962 that (I) (we) last saw the deceased alive on <u>1/24/62</u> 1962 and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Herman C. Kruganski</u> M.D.				22b. ADDRESS <u>509 Veirshill Rd Rockville, Md.</u>		22c. DATE SIGNED <u>1/24/62</u>	
23a. PHYSICIAN'S NAME (Type) <u>Herman C. Kruganski</u>							
23b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23c. DATE THEREOF <u>Jan. 27, 1962</u>		23d. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23e. LOCATION (City, town, or county) <u>Rockville</u> (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jayson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Thos. J. Kravos</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled out. The funeral director, after this certificate has been signed by the attending physician and completely filled out, should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00794  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN D <u>5 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>3520 QUESADA STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CAREY</u> 4. DATE OF DEATH <u>JAN. 28 1962</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/7/91</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>28</u> Hours <u>14</u> Min. <u>0</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>PHIL DULANEY</u> 14. MOTHER'S MAIDEN NAME <u>ALICE WILHART</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u> 16. SOCIAL SECURITY NO. <u>577-05-1761</u> 17. INFORMANT <u>Wife Beulah (Same as above)</u>		Address <u>465X</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarct, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary thrombosis, right and left pulmonary arteries</u> DUE TO (c) <u>longestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour <u>19</u> a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 23rd, 1962</u> to <u>Jan. 28th, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan. 28th, 1962</u> and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Robert Coale</u> 22b. DATE SIGNED <u>Jan. 28th, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert Coale</u>		22d. ADDRESS <u>4630 Montgomery Ave, Bethesda, Md.</u>		22e. REC'D BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-30-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ruckersville Cemetery</u>	
23d. LOCATION (City, town or county) (State) <u>Ruckersville Va</u>		23e. REGISTRAR'S SIGNATURE <u>Charles L. Hines</u>		23f. DATE <u>JAN 31 1962</u>	





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

00795 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (Outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
c. LENGTH OF STAY IN 1b <u>D.C.A.</u>				d. STREET ADDRESS <u>11300 Creekshore Dr. PL.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vincent</u> Middle <u>—</u> Last <u>Durkin</u>		4. DATE OF DEATH Month <u>January</u> Day <u>11</u> Year <u>1962</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 21, 1961</u>		9. AGE (In years last birthday) yrs. <u>3</u> Months <u>21</u> Days <u>—</u>		10. IF UNDER 1 YEAR Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent Thomas Durkin</u>				14. MOTHER'S MAIDEN NAME <u>Jean DeAtley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Mr. Vincent Durkin - father</u>				Address <u>11300 Creekshore Dr. Rockville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> 475X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>upper Respiratory Infection</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>Found collapsed in bed</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>—</u> e.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Baosch</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. BAOSCH</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-13-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>				22d. LOCATION, City, town, or country <u>Montgomery Maryland</u>			
23. FUNERAL DIRECTOR <u>R.A. Ziska</u> <u>8434 Georgia Ave.</u>				24a. REC'D BY REGISTRAR <u>JAN 15 '62</u>			
24b. REG. STRAR'S SIGNATURE <u>Arthur S. Thomas</u>				25. SIGNATURE OF MEDICAL EXAMINER <u>—</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be recorded by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

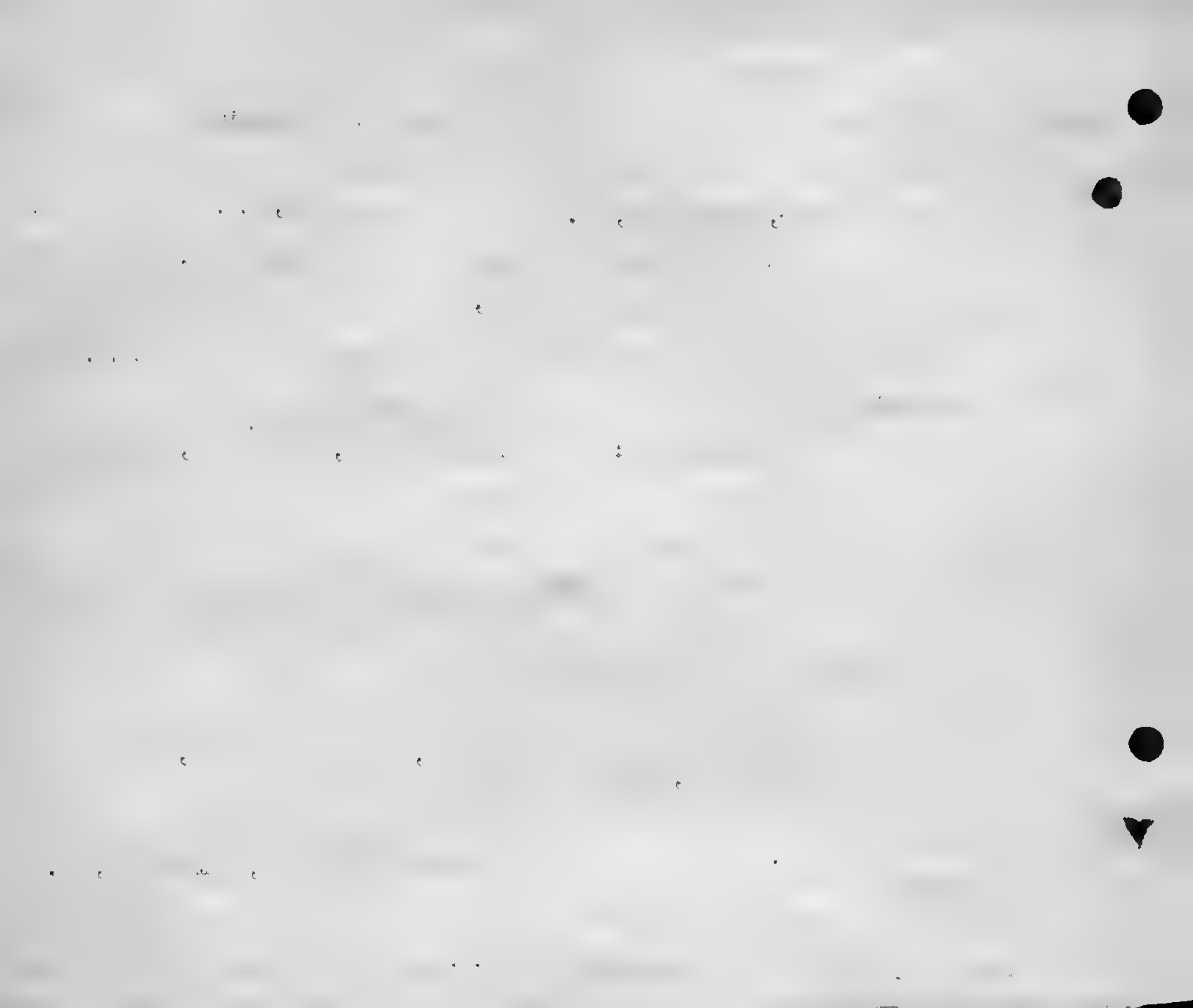
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00796

00790

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District Of Columbia</b> <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>3138 Stanton Road, S.E.</b>	
3. NAME OF DECEASED Type or print <b>Etta Mae Early</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24,</b> Year <b>19 62</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1907</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months <b>54</b> Days <b>17</b>	
11. IF UNDER 24 HRS. Hours <b>17</b> Mins. <b>17</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Lily ( Unknown )</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown, (If yes give dates of service)) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b>	
17. INFORMATION <b>The Medical Records</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> <b>134.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) <b>Aspergillosis, Right upper lobe</b> (c) <b>Acute Myelogenous Leukemia</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>		20. INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
21. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		22. INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH <b>NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>		23. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
24a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		24b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
25a. TIME OF INJURY Month, Day, Year Hour <b>e.m.</b> <b>19</b> p.m.		25b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25d. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>January 3, 1962</b> to <b>January 24, 1962</b> that (X) (we) last saw the deceased alive on <b>January 24, 1962</b> , and that death occurred at <b>10:50 P</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John C. Marsh</b>		22b. DATE SIGNED <b>January 25, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. Marsh</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-29-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>LINCOLN MEM.</b>		23d. LOCATION (City, town or county) (State) <b>SUITLAND MARYLAND</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Plummer</b>		25e. REC'D BY REGISTRAR <b>3015 12th Street, N.E.</b>	
25f. REGISTRAR'S SIGNATURE <b>Charles E. Harris</b>		25g. DATE <b>JAN 29 '62</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00797-111791

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park Md D.O.A.  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)  
a. STATE Maryland b. COUNTY Montgomery  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 10514 New Hampshire Ave Silver Spring  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) Chandler Streeter Eason

4. DATE OF DEATH  
Month 1 Day 26 Year 1962

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 5-12-01  
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales MGR. FLEC. CO. 10b. KIND OF BUSINESS OR INDUSTRY N.Y. 11. BIRTHPLACE (State or foreign country) USA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Seth Eason 14. MOTHER'S MAIDEN NAME Alida Streeter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT Mrs Nettie Eason - wife Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Coronary occlusion  
400-700 DUE TO  
Conditions (any, which gave rise to immediate cause (a), stating the underlying cause last. } b) Coronary insufficiency  
DUE TO  
(c) months  
INTERVAL BETWEEN ONSET AND DEATH months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Frank J. Broschert CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ DATE SIGNED 1-26-62  
EXAMINER'S NAME (Type) FRANK J. Broschert Address (Street, city, town, or county) (State)

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 1-29-62 22c. NAME OF CEMETERY OR CREMATORY Greenwood Cem. 22d. LOCATION City, town, or country (State) Brooklyn, N.Y.

23. FUNERAL DIRECTOR Foley, Connors & FH - Catonsville, Md ADDRESS 24a. REC'D BY REGISTRAR JAN 31 '62 24b. REGISTRAR'S SIGNATURE Christ S. Kiser



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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00798  
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00792

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN lb <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>305 Reading Ave.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>IRMINE Inerm. Edmonds</b> 5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>April 13-1876</b> 9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>Robert Edmonds Sparks</b> 14. MOTHER'S MAIDEN NAME <b>Oliver Sparks</b> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>Olive Carr-Daughter-same 2d</b> Address <b>Sparks River</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>153.8</b> <b>upper bowel obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>metastatic malignancy</b> (c) <b>Carcinoma of colon</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 yr</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Hour a.m. <b>19</b> Month, Day, Year <b>1962</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from... <b>1 Jan., 1962</b> to <b>4 Jan., 1962</b> that (I) (we) last saw the deceased alive on <b>4 Jan., 1962</b> and that death occurred at <b>10:30 AM</b> from the causes and on the date stated above 22a. SIGNATURE <b>Stephen N. Jones</b> 22c. PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b> 22d. ADDRESS <b>Veirs Mill Rod, Rockville, Maryland</b>		22b. DATE SIGNED <b>4 Jan 62</b> 22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS <b>Rockville, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1/6/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b> 25a. REG'D BY REGISTRAR <b>JAN 8 1962</b> 25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>	

2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00799  
00793

1. PLACE OF DEATH COUNTY <b>Montgomery</b> Maryland b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Maryland</b> c. LENGTH OF STAY IN b <b>10mo. 22days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wheaton Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> d. STREET ADDRESS <b>7019 Georgia ave. N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Edward J. Ehrmantraut</b> First Last M. d. n.		4. DATE OF DEATH Month Day Year <b>Jan. 20, 1962</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1883</b> yrs. 78
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plate printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>government</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Edward Philip Ehrmantraut</b>		14. MOTHER'S MAIDEN NAME <b>Ada St. John</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>17</b> INFORMANT <b>Mrs. Elizabeth M. Ehrmantraut (same as #2)</b> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma from Prostate</b> DUE TO <b>1777X</b> Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 15, 1962</b> to <b>Jan. 20, 1962</b> ; that (I) (we) last saw the deceased alive on <b>Jan. 13, 1962</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Walter K. Angervie</b> 22c. PHYSICIAN'S NAME (Type) <b>WALTER K. ANGERVIE</b>		22b. DATE SIGNED <b>Jan 20, 1962</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <b>6300 - 13<sup>th</sup> St. N.W. Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan 23, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur Walters</b>		25a. REC'D BY REGISTRAR <b>Jan 23 '62</b>	
ADDRESS <b>254 Carroll St. NW. DC</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. House</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9/60

Item 18-5162 arm 306  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00800 00796

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. STREET ADDRESS <u>3711 811 Duanhoe ST</u>	
3. NAME OF DECEASED (Type or print) <u>Danielle Christine Falck</u>		4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 62</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-6-61</u>
9. AGE (In years last birthday) <u>3</u> yrs. <u>2</u> mos. <u>5</u> days		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Erling H. Falck</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Giuffra</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Erling H Falck - Father</u>		Address	
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>PENDING</u> <u>Pulmonary congestion &amp; edema</u> (Marked) <u>SUDDEN</u>			
DUE TO (b) <u>Viral Interstitial pneumonitis</u>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brosch</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brosch</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>1/4/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Prince Georges County, Md.</u>	
23. FUNERAL DIRECTOR <u>The S.H. Hines Co. - Washington 9, D.C.</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JAN 4 '62</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00801

## CERTIFICATE OF DEATH

Reg. Dist. No.

001797

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8920 Ridge Place</u>				d. STREET ADDRESS <u>8920 Ridge Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Fay</u> Middle <u>B.</u> Last <u>Farquhar</u>				4. DATE OF DEATH Month <u>January</u> Day <u>30</u> Year <u>1962</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7, 1885</u>		9. AGE (In years last birthday) yrs <u>76</u>	IF UNDER 1 YEAR Months <u>8</u> Days <u>23</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lackey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edison Farquhar-son-same 2d</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Coronary artery occlusion</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>December, 1935</u> , to <u>January 30, 1962</u> , that I last saw the deceased alive on <u>January 30, 1962</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Warner Rice</u> E. WARNER RICE, M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 1150 Conn. Ave. N.W., Washington, D.C.</u> <u>1/30/62</u>			
PHYSICIAN'S NAME (Type) <u>1150 CONNECTICUT AVE., N.W.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 6 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If an inquest is held, the certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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Certificate  
Dr. Frank Broschart contacted  
Gave Consent for Dr. Trozzo to sign certificate  
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00802  
00794  
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hosp</u>		d. STREET ADDRESS <u>9302 Compton Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Walter Henry Ferber</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-22-97</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper Co</u>	
11. BIRTHPLACE (County & State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Ferber</u>		14. MOTHER'S MAIDEN NAME <u>Ida Gordon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WWI Navy</u>		16. SOCIAL SECURITY NO. <u>578 09 8723</u>	
17. INFORMANT <u>Mrs Nina M. Ferber - wife</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for a) (b), and (c.) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c), stating the underlying cause last. DUE TO <u>2 yrs +</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs +</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u></u> o.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>59</u> , to <u>Jan</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/18</u> , 19 <u>62</u> , and that death occurred at <u>8:00</u> AM, from the causes and on the date stated above			
22a. SIGNATURE <u>Frank M. Trozzo Jr.</u>		22b. DATE SIGNED <u>1/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK M TROZZO JR.</u>		22d. ADDRESS <u>3501 HAMILTON ST HYTS MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 24, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Prince George Co. Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>	
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. F...</u>	





Charles L. Hines

VR A15 (4)  
15M 9/60

OR ATTENDING PHYSICIAN: The law requires that the  
may be retained by the hospital or attending physician  
DIRECTOR: After this certificate has been signed

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00804

00728

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4319 East West Hwy</u>	
3. NAME OF DECEASED (Type or print) <u>Alberta M. Flack</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/77</u>
9. AGE (in years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Flack</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Bear</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of serv. ce.) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Bessie B. Branzell</u>		Address <u>4319 East West Hwy Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebrovascular Accident</u> DUE TO (c) <u>Arteriosclerosis, Generalized</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>  </u> p.m. <u>  </u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/27/62</u> 19 <u>62</u> to <u>1/30/62</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/29/62</u> 19 <u>62</u> , and that death occurred at <u>9:50</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs</u>		22b. DATE SIGNED <u>1/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs</u>		22d. ADDRESS <u>7720 Wisconsin Ave. Beth. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/2/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>FEB 6 '62</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL, PAS-  
death, Pas-  
TO FUNERAL DIRECTOR, PAS-  
director, page 3 should be  
be filed with the State Dept. of Health prior to burial, cremation, or re-

VR A15 (4)  
15M 9/60



00805

CERTIFICATE OF DEATH

Item 1 Film G-305 1/17/62 iwk

00799

1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Bethesda

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

The Clinical Center, Bethesda 14, Md.

3. NAME OF DECEASED (Type or print)

Ellis

Caperton

Flanagan

5. SEX

6. COLOR OR RACE

Male

White

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

December 12, 1892

9. AGE (In years last birthday)

69 yrs.

10. IF UNDER 1 YEAR

Months Days

11. IF UNDER 24 HRS.

Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Clerical

11. BIRTHPLACE (County & State, or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Flanagan

Dora Corroll

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)

Yes World War I

16. SOCIAL SECURITY NO.

487-07-9234

17. INFORMANT

The Medical Record

The Clinical Center, Bethesda

18. CAUSE OF DEATH (Enter on y one cause per line for a) (b) and (c)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e)

Peripheral Vascular Failure

DUE TO

Chronic Lymphatic Leukemia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

7 months

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.

19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (this hospital) attended the deceased from August 25, 1961 to January 10, 1962, that (we) last saw the deceased alive on January 10, 1962, and that death occurred at 1:34 PM from the causes and on the date stated above.

22a. SIGNATURE

Carl J. Bentzel

22c. PHYSICIAN'S NAME (Type)

Carl J. Bentzel, M.D.

ATTENDING PHYS. ☐

MED. DIRECTOR ☐

STAFF PHYS. ☒

22b. DATE SIGNED

1/11/62

22d. ADDRESS

The Clinical Center, National Institutes of Health, Bethesda 14, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

1/12/62

23c. NAME OF CEMETERY OR CREMATORY

Arlington Cemetery

23d. LOCATION (City, town or county)

Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE

Robert A. Pumphrey, Bethesda, Maryland

ADDRESS

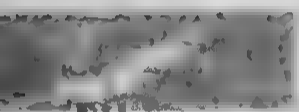
25a. REC'D BY REGISTRAR

DATE

JAN 15 '62

25b. REGISTRAR'S SIGNATURE

Arthur J. Haines



0 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00806

00806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRETT PARK</u> d. STREET ADDRESS <u>10934 Montrose Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Ann</u> Last <u>Freer</u> 4. DATE OF DEATH Month <u>JAN</u> Day <u>6</u> Year <u>1962</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>2/20/43</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter Walker</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Hess</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Charles A Freer (son)</u> Address <u>same as above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Rheumatic Heart Disease and 40 yrs</u> DUE TO (c) <u>Severe Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) <u>-</u> INTERVAL BETWEEN ONSET AND DEATH <u>-</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>None</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>-</u> 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/3, 1961</u> to <u>1/5, 1962</u> ; that (I) (we) last saw the deceased alive on <u>1/5, 1962</u> , and that death occurred <u>2/5 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>John B. Chubb</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>JOHN B. CHUBB</u> 22d. ADDRESS <u>8805 Conn Ave. Ch. Co. Md</u> 22b. DATE SIGNED <u>1/6/62</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-9-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Ziska</u> Warner B. Pumphrey, Inc. 4434 ADDAMS Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR <u>JAN 11 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO MEDICAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Dist of Columbia</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Takoma Park D.C.A.</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Washington D C 47x3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Stn + Hosp</u>		d. STREET ADDRESS <u>1356 Iris St NW</u>	
3. NAME OF DECEASED (Type or print) <u>John Thomas Gable</u>		4. DATE OF DEATH <u>1-11-1962</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-31-90</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>us. kept at war</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
13. FATHER'S NAME <u>John Gable</u>		14. MOTHER'S MAIDEN NAME <u>Agnes King</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 41) <u>X</u> DUE TO <u>MITRAL INSUFFICIENCY</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>X</u> DUE TO <u>FRACTURE, LEFT 10th RIB, AXILLARY LINE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Struck by auto while driving at intersection</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>10:25 p.m. 12-30 1961</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.) <u>Struck by auto while driving at intersection</u>	
20c. TIME OF INJURY Month, Day, Year <u>12-30 1961</u>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	
20e. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20f. (City or town) <u>Adams Morgan Ind</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Frank J. Broschank</u>		22b. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschank</u>		22c. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-12-62</u>	
22d. BURNAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22e. LOCATION (City, town, or country) <u>Rockville MD.</u>	
22f. DATE THEREOF <u>15 JAN. 1962</u>		22g. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>	
23. FUNERAL DIRECTOR <u>Michael J. Linsell</u>		24. REC'D BY REG. STRAR <u>Arthur E. Hines</u>	
ADDRESS <u>1700 GEORGETOWN AVENUE</u>		DATE <u>JAN 15 '62</u>	

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23



CERTIFICATE OF DEATH

Reg. Dist. No. 1118102

00808

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1, Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>3 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>715 Lenmar Ave. Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bradford Rest Home</u>		d. STREET ADDRESS <u>715 Lenmar - 23A</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First <u>S.</u> Middle <u>Gaither</u> Last		4. DATE OF DEATH <u>Jan.</u> Month <u>22</u> , 19 <u>62</u> Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Hodge</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Lynn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>577-24-1135</u>		17. INFORMANT <u>George Gaither, son</u> Address <u>715 Lenmar - 23A Rockville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>445X</u> DUE TO (b) <u>Malignant Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Nephrosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>many years</u> <u>many years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obesity, Somatic</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7-15</u> , 19 <u>60</u> , to <u>1-20</u> , 19 <u>62</u> ; that I last saw the deceased alive on <u>1-22</u> , 19 <u>62</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clive E. Jackson, M.D.</u>		ADDRESS (Street, city or town, state) <u>202 Martin Lane Rockville, Md.</u> DATE SIGNED <u>1-23-62</u>	
PHYSICIAN'S NAME (Type) <u>Robert L. Snowler</u>		ADDRESS <u>Rockville, Md.</u>	
22a. BURIAL, CREMATION, REINTERMENT (Specify)	22b. DATE THEREOF <u>1/25/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion,</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Zion, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowler</u>		24a. REC'D BY REGISTRAR <u>JAN 26 '62</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Clive E. Jackson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 may be retained by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00809  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>327-F. ST. WASH. D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BELMONT NURSING HOME</u>		d. STREET ADDRESS <u>327-F. ST. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Giorgio</u> First <u>GIANCOLI</u> Middle Last		4. DATE OF DEATH <u>JAN. 2</u> 19 <u>62</u> Month Day Year	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 15, 1899</u> yrs. 62	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WILLARD Hotel</u>	
11. BIRTHPLACE (County & State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>ITALY</u>	
13. FATHER'S NAME <u>JOSEPH GIANCOLI</u>		14. MOTHER'S MAIDEN NAME <u>KATHERINE LAZZARI</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>VALENTE GIANCOLI</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>322</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) <u>cerebral thrombosis</u> <u>cerebral embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos - 7 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>Nov., 1961</u> , to... <u>1/2/62</u> , that (I) (we) last saw the deceased alive on... <u>12/20/61</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>D Nelson</u> M.D.		22b. DATE SIGNED <u>1/2/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>D NELSON</u>		22d. ADDRESS <u>10670 GA. AVE. S.W. Sp. Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/6/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Olivet Cem,</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>5</u> '62	
ADDRESS <u>300-4th St. N.E. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Lee S. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician and completed and filled in by the funeral director. After this certificate has been signed by the attending physician and completed, please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>15 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2918 Legation St., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Harry Albert GILTNER</b>		4. DATE OF DEATH Last Month Day Year <b>January 16 1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6 November 1878</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Indiana</b>	
11. BIRTHPLACE (County and State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin L. Giltner</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Luiza Mount</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Mrs. Virginia B. Giltner</b>	
17. INFORMANT <b>Mrs. Virginia B. Giltner</b>		Address <b>2918 Legation St. NW Washington, D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Arteriosclerotic heart disease and Generalized Arteriosclerosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 2</b> 19 <b>62</b> to <b>Jan. 16</b> 19 <b>62</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 16</b> 19 <b>62</b> , and that death occurred at <b>2:20 PM</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Larry J. Hines</b>		22b. DATE SIGNED <b>January 17, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>LARRY J. HINES, CDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-19-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines</b>		25a. REC'D BY REGISTRAR <b>JAN 19 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Walter L. Hines</b>			

1000



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00811

00835

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>C &amp; O Canal</u>		d. STREET ADDRESS <u>5511 Barling Ct</u>	
3. NAME OF DECEASED (Type or print) <u>Raymond H. Godine</u>		4. DATE OF DEATH <u>June 13 1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-1906</u>	
9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Godine</u>		14. MOTHER'S MAIDEN NAME <u>Belle Prime</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-8923</u>	
17. INFORMANT <u>Lucille Godine-Wife-same above</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and c.)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420</u> DUE TO (b) <u>(Collapsed while ice skating)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT.ON GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>1/15/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		22d. LOCATION (City, town, or country) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 16 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fina</u>			

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be completed by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00812

00806

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>DADE</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>miami Springs</u> d. STREET ADDRESS <u>64th Ave. 3940 N. West</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence May Cullen Golsen</u> First Middle Last		4. DATE OF DEATH <u>Jan. 2 1962</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>wh</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-97</u> Month Day Year
9. AGE (In years last birthday) <u>64 yrs</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auditor (RET.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Home &amp; Finance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>	
13. FATHER'S NAME <u>Albert J. Cullen</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Krall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sanitarium Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Massive bleeding Duodenal ulcer</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>541.0</u> DUE TO (c) <u>terminal</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1961</u> to <u>Jan 2, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 2, 1962</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u> M.D.		22b. DATE SIGNED <u>1/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare M.D.</u>		22d. ADDRESS <u>7600 Carroll Ave. T.P. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Ziska</u> W. J. Humphrey Inc.		25. REC'D BY REGISTRAR <u>JAN 5 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>J. H. Hare</u>			



CERTIFICATE OF DEATH

Reg. Dist. No. 00813

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>9 years</u>		d. STREET ADDRESS <u>6505 Greenleaf Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u>		4. DATE OF DEATH <u>January 27</u> 19 <u>62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 12 1893</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Simon Epstein</u>		14. MOTHER'S MAIDEN NAME <u>Tamara Kaplan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Sidney H Greenfield</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 4-20-62 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 Asthma 2 Upper respiratory infection 3 Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/8/62</u> , 19 <u>  </u> , to <u>1/29/62</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>1/28/62</u> , 19 <u>  </u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Patrick C. Jameson</u> M.D.		DATE SIGNED <u>1/29/62</u>	
PHYSICIAN'S NAME (Type) <u>Patrick C. Jameson</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-31-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>		22d. LOCATION (City, town or county) (State) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc 2100 Eutan Place</u>		24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>JAN 31 '62</u>		<u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00814

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		d. STREET ADDRESS <b>2402 Menokin Drive, Apt. 103</b>	
3. NAME OF DECEASED (Type or print) <b>Helen Mae Greiner</b>		4. DATE OF DEATH <b>January 18, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 28, 1904</b>
9a. AGE (In years last birthday) <b>57</b>		9b. IF UNDER 1 YEAR Months <b>5</b> Days <b>20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Min.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph B. Moore</b>		14. MOTHER'S MAIDEN NAME <b>Hetty P. Kelly</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>HUSBAND: James L. Greiner, Same as #</b>	
17. INFORMANT <b>HUSBAND: James L. Greiner, Same as #</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>asphyxia</b> DUE TO <b>Pulmonary Metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Carcinoma of Cervix</b> DUE TO <b>Carcinoma of Cervix</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>5 mos. 20 mos.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from... <b>Nov. 16, 1961</b> to... <b>Jan. 18, 1962</b> that (we) last saw the deceased alive on... <b>Jan. 18, 1962</b> and that death occurred at... <b>2:53 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Louis E. Potvin</b>		22b. DATE <b>January 18, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. POTVIN, LCDRMC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-18-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lee's Funeral Home, 4th &amp; Massachusetts Ave. NE</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 22 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00815  
CERTIFICATE OF DEATH

00809

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bensington</u> c. LENGTH OF STAY IN 1b		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Allegheny</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wilkinsburg</u> <u>75x-3</u> d. STREET ADDRESS <u>721 Midland St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL Hall Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Valerie</u> <u>HAGARA</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Jan. 5</u> 19 <u>62</u> Month Day Year	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Oct 20, 1878</u> <u>83</u> yrs.
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House-Wife</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Hungary</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A</u>		<b>13. FATHER'S NAME</b>	
<b>14. MOTHER'S MAIDEN NAME</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>16. SOCIAL SECURITY NO</b> <b>17. INFORMANT</b> <u>Alexander Hagara, as above</u> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> 4 30 . 0 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis</u> (c) <u>Hypostatic pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>May 2</u> 19 <u>57</u> <b>to</b> <u>Jan 4</u> 19 <u>62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 4</u> 19 <u>62</u> <b>and that death occurred at</b> <u>12:45</u> P.M. <b>from the causes and on the date stated above.</b>		<b>22a. SIGNATURE</b> <u>Alfred S. Norton</u> <b>22b. DATE SIGNED</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Alfred S. Norton, M.D.</u>		<b>22d. ADDRESS</b> <u>4711 Highland Ave., Bethesda 14, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>1/8/62</u>		<b>23b. DATE THEREOF</b> <u>1/8/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Channein Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Wilkinsburg, Pa.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>M. C. Kree, 800 Center St., Pgh 21</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 10 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles S. Thomas</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00816

00810

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>10 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1508 Windham Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Beverly WAITE Hardy</u>		<b>4. DATE OF DEATH</b> Month <u>JAN.</u> Day <u>7</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept 30 1916</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>TYPIST</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Gov't.</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Illinois</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Raymond Waite</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARJORIE Thurnett</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>	
<b>17. INFORMANT</b> <u>William Hardy (husband)</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Coma</u> <u>501.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cirrhosis liver</u> (a), stating the underlying cause last. DUE TO (c) <u></u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 days</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
<b>20c. TIME OF INJURY</b> Hour <u>19</u> a.m. <u></u> p.m. <u></u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u>	<b>20f. (City or town) (County) (State)</b> <u></u>
<b>21. I certify that (I) (this hospital) attended the deceased from <u>Jan 5/5 1962</u> to <u>Jan 7 1962</u>, that (I) (we) last saw the deceased alive on <u>Jan 6 1962</u> and that death occurred at <u>11:35 A.M.</u> from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Patrick C. Jameson</u> M.D.		<b>22b. DATE SIGNED</b> <u>1/7/62</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>PATRICK C. JAMESON</u>		<b>22d. ADDRESS</b> <u>12020 Georgia Silver Spring Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>Jan. 10, 1962</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cemetery</u>	<b>23d. LOCATION (City, town or county) (State)</b> <u>Prince Geo. Co., Md.</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Jan 11 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Warner E. Humphrey</u>		<b>25c. REGISTRAR'S NAME</b> <u>Warner E. Humphrey</u>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9/60

<div> <div> <div>Item 18 11-13-62</div> <div>6-62</div> </div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>00811</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>00811</div> </div>											
<b>1. PLACE OF DEATH</b> <div>a. COUNTY</div> <div>Montgomery</div> <div>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>Bethesda</div> <div>c. LENGTH OF STAY IN (b)</div> <div>24 days</div> <div>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</div> <div>The Clinical Center, Bethesda 14, Md.</div>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution. Residence before admission) <div>a. STATE</div> <div>District of Columbia</div> <div>b. COUNTY</div> <div>Washington</div> <div>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)</div> <div>477-13</div> <div>d. STREET ADDRESS</div> <div>2319 Savannah Street, S.E.</div>				<div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div>			
<div>3. NAME OF DECEASED (Type or print)</div> <div>Rose Elizabeth Hargrove</div>		<div>4. DATE OF DEATH</div> <div>January 20 19 62</div>		<div>5. SEX</div> <div>Female</div>		<div>6. COLOR OR RACE</div> <div>Negro</div>		<div>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div>		<div>8. DATE OF BIRTH</div> <div>December 18, 1937 24</div>	
<div>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Practical Nurse</div>		<div>10b. KIND OF BUSINESS OR INDUSTRY</div> <div>Nursing</div>		<div>11. BIRTHPLACE (State or foreign country)</div> <div>Washington, D.C.</div>		<div>12. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div>		<div>13. FATHER'S NAME</div> <div>Wesley Gilbert</div>		<div>14. MOTHER'S MAIDEN NAME</div> <div>Bertha Fennell</div>	
<div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</div> <div>No</div>		<div>16. SOCIAL SECURITY NO.</div> <div>Unascertainable</div>		<div>17. INFORMANT</div> <div>The Medical Record</div>		<div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div>Subacute bacterial endocarditis - mitral valve</div>		<div>INTERVAL BETWEEN ONSET AND DEATH</div>		<div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>	
<div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div>IMMEDIATE CAUSE (a)</div> <div>410 X</div> <div>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> </div> <div> <div>DUE TO</div> <div>(b)</div> <div>Rupture of chordae tendineae, mitral valve</div> </div> <div> <div>DUE TO</div> <div>(c)</div> <div>Mitral insufficiency</div> </div> </div>											
<div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</div>											
<div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div>				<div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)</div>							
<div>20c. TIME OF INJURY</div> <div>Hour a.m. p.m.</div> <div>Month, Day, Year</div> <div>19</div>				<div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div>		<div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div>		<div>20f. (City or town)</div> <div>(County)</div> <div>(State)</div>			
<div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/></div>											
<div>ACTUAL SIGNATURE</div> <div>Frank J. Broschart</div>				<div>CHIEF MEDICAL EXAMINER <input type="checkbox"/></div>				<div>DATE SIGNED</div> <div>1/20/62</div>			
<div>EXAMINER'S NAME (Type)</div> <div>Frank J. Broschart, M.D.</div>				<div>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></div>				<div>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></div>			
<div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div>				<div>22b. DATE THEREOF</div> <div>1/25/62</div>		<div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>Arlington National Cem.</div>		<div>22d. LOCATION (City, town, or country)</div> <div>Arlington, Virginia</div>		<div>22e. ADDRESS</div> <div>3015-12th St. NE</div>	
<div>23. FUNERAL DIRECTOR</div> <div>John T. Phelan Co.</div>				<div>24a. REC'D BY REGISTRAR</div> <div>JAN 26 '62</div>				<div>24b. REGISTRAR'S SIGNATURE</div> <div>John T. Phelan</div>			

MEDICAL CERTIFICATION



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00818

CERTIFICATE OF DEATH

Item 10b, film G306 2/2/62 iwk

00818

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5300 Westbard Avenue</u>		d. STREET ADDRESS <u>5300 Westbard Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>George J. Harris, Sr.</u>		4. DATE OF DEATH <u>Jan. 18 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1906</u>	
9. AGE (In years last birthday) <u>56 yrs</u>		10. IF UNDER 1 YEAR <u>0</u> Months <u>4</u> Days	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assist. V. Pres. Assoc. of American Railroads</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Harris</u>		14. MOTHER'S MAIDEN NAME <u>Mary Taylor</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 2 578-05-2132</u>	
17. INFORMANT <u>Beulah Harris-Wife-same 2d</u>		Address	
18. CAUSE OF DEATH (Enter on, y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, <u>162.1</u> DUE TO <u>162.1</u> DUE TO <u>162.1</u> PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour <u>e.m.</u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 30 1959</u> to <u>Jan. 18 1962</u> , that (I) (we) last saw the deceased alive on <u>1-17-62</u> 19 <u>62</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. William S. Detwiler</u> M.D.		22b. DATE SIGNED <u>1/18/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. William S. Detwiler</u>		22d. ADDRESS <u>418 - 1025 Conn. Ave. NW Washington, DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/22/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Jan 23 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>	

SECRET



TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be completed by the hospital or attending physician and completely filled in by the funeral director. Part 2 may be completed by the attending physician and completely filled in by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00819  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>300 Normandy Drive</b>		d. STREET ADDRESS <b>300 Normandy Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Hester</b> Middle <b>Bruce</b> Last <b>Harris</b>		4. DATE OF DEATH Month <b>January</b> Day <b>23</b> Year <b>1962</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/1889</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Mins. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Virginia</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Perkins</b>		14. MOTHER'S MAIDEN NAME <b>Ella Pollard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mrs. Thomas C. Vickers</b>		Address <b>300 Normandy Dr. Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. <b>Diabetes</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 23 1962</b> to <b>Jan 23 1962</b> ; that (I) (we) last saw the deceased alive on <b>Jan 23 1962</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John N. Andrews</b> M.D.		22b. DATE SIGNED <b>1-23-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>John N. Andrews</b>		22d. ADDRESS <b>19601 Colesville Rd Silver Spring Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/26/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl. Cem.</b>	23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Himes Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 25 1962</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Ing L. Hines</b>	



TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7,61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00820		00814	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Olney</u> c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brooke Grove Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase 53</u> d. STREET ADDRESS <u>24 W Irving ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaretha W. Harris</u> First Middle Last 5. SEX <u>f</u> 6. COLOR OF RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Jan 13 1873</u> 9. AGE (In years, last birthday) <u>88</u> yrs. <u>88</u> Months <u>8</u> Days <u>2</u> Hours <u>19</u> Min.		4. DATE OF DEATH <u>January 2 1962</u> Month Day Year 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pittsburg Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Dr Lewis H. Harris</u> 14. MOTHER'S MAIDEN NAME <u>Frances C Myers</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>E &amp; E Ellis 24 W Irving ST md.</u> Address <u>Chevy Chase 53</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Nephritis (urine)</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>Yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2304</u> 20f. (City or town) <u>1/2</u> (County) <u>1/2</u> (State) <u>1/2</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1939</u> to <u>1/2 1962</u> that (I) (we) last saw the deceased alive on <u>12/29 1961</u> and that death occurred <u>2:30 PM</u> from the causes and on the date stated above.		22b. DATE SIGNED <u>1/2/62</u>	
22a. SIGNATURE <u>O. H. Ligon</u> 22c. PHYSICIAN'S NAME (Type) <u>O. H. Ligon</u>		22d. ADDRESS <u>Sandy Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> 23b. DATE THEREOF <u>1/2/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> 23d. LOCATION (City, town or county) <u>Suitland, Maryland</u> (State) <u>MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u> ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00821

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00815

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clinton</u> c. LENGTH OF STAY IN <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Monty General Hosp</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Toney Antonio Hawkins</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>Jan 15 1962</u> Month Day Year		<b>9. AGE</b> (In years last birthday) <u>3</u> <b>IF UNDER 1 YEAR</b> <u>3</u> <b>IF UNDER 24 HRS.</b> <u>12</u> yrs. Months Days Hours Min.			
<b>5. SEX</b> <u>male</u> <b>6. COLOR OR RACE</b> <u>col</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9-22-61</u> <b>9. WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (State or foreign country) <u>md</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C.</u>		<b>13. FATHER'S NAME</b> <u>Karleton Hawkins</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Hawkins</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mary Hawkins</u> Address <u>Stun 2</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>175X</u> DUE TO <u>Asphyxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>supp Respiratory Infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>1-15-62</u> Address (Street, city, town, or county) <b>22a. BURIAL, CREMATION, OR OTHER DISPOSAL</b> (Specify) <u>1/18/62</u> <b>22b. DATE THEREOF</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Park.,</u> <b>22d. LOCATION</b> (City, town, or country) (State) <u>Rockville, Md.</u>							
<b>23. FUNERAL DIRECTOR</b> <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 18 '62</u> DATE		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hays</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate may be retained by the funeral director for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
00822  
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>4 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12902 Holdridge Road</b>		e. STREET ADDRESS <b>12902 Holdridge Road</b>	
3 NAME OF DECEASED (Type or print) First <b>Jessie Josephine</b> Middle <b>(England)</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 10, 1880</b>
9. AGE (in years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>12</b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Payne England</b>		14. MOTHER'S MAIDEN NAME <b>Mary Legg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Francis O'Connor-Daughter-same 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO (b) <b>Atelectasis</b> DUE TO (c) <b>Cerebral thrombosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinsonism</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 days</b> <b>7 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 19, 1962</b> to <b>Jan 22, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 21, 1962</b> , and that death occurred at <b>5 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>1/22/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIC.</b>		22d. ADDRESS <b>2641 Colson Rd Silver Spring, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/23/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 23 62</b>	
		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	





## CERTIFICATE OF DEATH

Reg. Dist. No.

00823

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10103 Dickens Avenue</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Arthur</b> Middle <b>Hill</b> Last				4. DATE OF DEATH <b>January</b> Month <b>19</b> Day <b>1962</b> Year			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 6, 1889</b>	9. AGE (In years last birthday) <b>72</b> yrs	10. IF UNDER 1 YEAR: Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hearing Aid Business - Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Frederick Hill</b>			
14. MOTHER'S MAIDEN NAME <b>Alexandria McLean</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO <b>292-07-4078</b>				17. INFORMANT <b>Anna Marie Hill</b> Address <b>10103 Dickens Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Obstructive Renal Failure</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Prostate</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 years +</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>Sept.</b> , 19 <b>61</b> , to <b>present</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>January 8</b> , 19 <b>62</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John F. Gustafson</b> M.D. <b>915 19th Street, N.W.</b> ADDRESS (Street, city or town, state) <b>Jan. 19, 1962</b> DATE SIGNED				PHYSICIAN'S NAME (Type) <b>JOHN F. GUSTAFSON</b> <b>Washington 6, D.C.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>1-19-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 23 '62</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Hanna</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00824

## CERTIFICATE OF DEATH

00818

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Suburban Hospital Bethesda</u> c. LENGTH OF STAY IN 1b <u>15 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery to Suburban Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>536 Madison Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles HENRY HOCHGESANG</u> First Middle Last		4. DATE OF DEATH <u>Jan. 28 1962</u> Month Day Year	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 15 1889 72</u> Yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inst. manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Bur. Standard</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Oxford - New Jersey</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Charles Hochgesang</u> 14. MOTHER'S MAIDEN NAME <u>Mary Blessing</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>Wife 536 Madison ST. N.W.</u> Address			
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pulmonary emphysema and Chronic interstitial pulmonary fibrosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a <u>Congestive heart failure (recent)</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. City or town (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> 19 <u>59</u> to <u>1-28</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-28</u> 19 <u>62</u> and that death occurred at <u>10:38</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Youngblood</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD, M.D.</u>		22b. DATE SIGNED <u>1-29-62</u> 22d. ADDRESS <u>WASHINGTON CLINIC, WASHINGTON 15</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-31-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> 25a. REC'D BY REGISTRAR <u>JAN 31 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>	



## MEDICAL CERTIFICATION

VR A15 {4}  
15M 9/60



TO HOSPITAL OR A MOUNTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-61

Item 1-19-62 File # 305 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 00826 00820									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>40 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Gaithersburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt.#1, Box 231</b> d. STREET ADDRESS <b>IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>				
3. NAME OF DECEASED (Type or print) <b>Robert (N) Horton</b>					4. DATE OF DEATH <b>January 7 1962</b>				
5. SEX <b>Male</b> 6. COLOR OR RACE <b>Caucasian</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <b>February 8 1893</b> 9. AGE (In years last birthday) <b>68</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b> 11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>									
13. FATHER'S NAME <b>Robert Horton</b> 14. MOTHER'S MAIDEN NAME <b>Molly Mollie</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes WWI</b> 16. SOCIAL SECURITY NO. <b>Wife Ethel Horton</b> 17. INFORMANT <b>Same as #2</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach with widespread metastases</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>metastases</b> (c) DUE TO cause last, (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>				
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18) 20c. TIME OF INJURY Month, Day, Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, County (State)									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 November, 1961</b> to <b>7 January, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>7 January, 1962</b> , and that death occurred <b>0045AM</b> from the causes and on the date stated above.									
22a. SIGNATURE <b>A.T. Thorp Jr.</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>A.T. THORP LT MC USN</b>					22b. DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md.</b>				
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>1-10-62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b> 23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>					25a. REC'D BY REGISTRAR <b>Gartners Funeral Home, 316E Diamond Ave., Gaithersburg, Md.</b> 25b. REGISTRAR'S SIGNATURE <b>DATE JAN 9 '62</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00827

00821

<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>2 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LAUREL</b> d. STREET ADDRESS <b>LEISHEAR ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>WALTER</b> Middle <b>MCBAIN</b> Last <b>HOWES</b>		<b>4. DATE OF DEATH</b> Month <b>1</b> Day <b>16</b> Year <b>19 62</b>	
<b>5. SEX</b> <b>MALE</b> <b>6. COLOR OR RACE</b> <b>WHITE</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>10/13/84</b> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <b>77</b> yrs. <b>IF UNDER 1 YEAR</b> Months <b>16</b> Days <b>19</b> <b>IF UNDER 24 HRS.</b> Hours <b>62</b> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b> <b>13. FATHER'S NAME</b> <b>JAMES HOWES</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Farm</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>no</b> <b>16. SOCIAL SECURITY NO.</b> <b>None</b> <b>17. INFORMANT</b> <b>WILLIE DWYER</b> Address _____		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATEAL</b> <b>441X</b> <b>TRACHEO BRONCHITIS, ACUTE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>ACUTE ANEURYSM</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C-22X</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour <b>19</b> e.m. <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>SANDY SPRING, MARYLAND</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from Jan 15 1963 to Jan 16 1964, that (I) (we) last saw the deceased alive on Jan 16 1963, and that death occurred at 12:35 P.M. from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>A. D. Bonifant, M.D.</b> <b>22b. DATE SIGNED</b> <b>JAN 19 '62</b>		<b>22c. PHYSICIAN'S NAME</b> (Type) <b>A. D. BONIFANT, M.D.</b> <b>22d. ADDRESS</b> <b>SANDY SPRING, MARYLAND</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b> <b>23b. DATE THEREOF</b> <b>1-19-62</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Carmel</b> <b>23d. LOCATION</b> (City, town or county) <b>Sunshine, Md.</b> (State)		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Francis H. Barber</b> <b>ADDRESS</b> <b>Laytonsville, Md.</b> <b>25a. REC'D BY REGISTRAR</b> <b>JAN 19 '62</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanna</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be relied upon by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G505 1/22/62 1wk

00828

# CERTIFICATE OF DEATH

Reg. Dist. No.

00822

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd</b>				b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd</b>				c. LENGTH OF STAY IN TB <b>61 yrs</b>				d. STREET ADDRESS <b>1</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>RUSSELL SMITH HOYLE</b>				4. DATE OF DEATH Month Day Year <b>JANUARY 15 1962</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1900</b> <b>Nov. 27-1900</b>		9. AGE (In years last birthday) <b>61</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Invalid--</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Smith Hoyle</b>				14. MOTHER'S MAIDEN NAME <b>Ella May Watkins</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.				INFORMANT <b>Mrs Smith Hoyle, Boyd, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>473X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>January 1950</b> to <b>Jan 15 1962</b> that I last saw the deceased alive on <b>14 Jan 1962</b> and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>P.O. Boyd, Md</b> DATE SIGNED <b>1/15/62</b> ACTUAL SIGNATURE <b>John Fawcett</b> M.D. PHYSICIAN'S NAME (Type) <b>John Fawcett</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/17/62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Presbyterian</b>				22d. LOCATION (City, town, or county) (State) <b>Boyd, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William B. Hilton</b>						24a. REC'D BY REGISTRAR DATE <b>JAN 19 '62</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00829

CERTIFICATE OF DEATH

00823

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN <u>14 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Boyd's</u> d. STREET ADDRESS <u>Box 201 Route #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY GIRL HUSBAND</u>		4. DATE OF DEATH <u>JANUARY 24 1962</u> Month Day Year	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 24 1962</u> Year Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES NOAH HUBBARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY LOU BOARMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>FATHER.</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> 751.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) <u>Atelectasis of lungs</u> (c) <u>Hydrocephalus &amp; Spina Bifida</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lecture, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> 19 <u>62</u> , to <u>1/24</u> 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>62</u> , and that death occurred at <u>3:17 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William F. Colleton</u> M.D.		22b. DATE SIGNED <u>1/24</u>	
22c. PHYSICIAN'S NAME (Type) <u>—</u>		22d. ADDRESS <u>—</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>1-26-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUBURBAN HOSPITAL</u>		23d. LOCATION (City, town or county) (State) <u>BETHESDA, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>AMELIA C. CARTER, ADMIN. - (per F.O.)</u>		25a. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
ADDRESS <u>SUBURBAN HOSP. BETHESDA, M.D.</u>		DATE <u>JAN 30 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. In by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 11-60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00830  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>98 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Georgia</b> b. COUNTY <b>Sumerville, Ga</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Sumerville, Ga</b> d. STREET ADDRESS <b>Route # 4</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																															
3. NAME OF DECEASED (Type or print, First Middle Last) <b>Mary Emma Hughes</b>				4. DATE OF DEATH Month Day Year <b>January 29 1962</b>				5. SEX <b>Female</b>				6. COLOR OR RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>September 28, 1902</b>				9. AGE (in years, last birthday) <b>59 yrs.</b>				IF UNDER 1 YEAR Months Days Hours Min. <b>59</b>				IF UNDER 24 HRS. <b>59</b>																											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>												10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>												11. BIRTHPLACE (County & State, or foreign country) <b>Georgia</b>												12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>																							
13. FATHER'S NAME <b>Henry Bridges</b>												14. MOTHER'S MAIDEN NAME <b>Leobelle Payton</b>												15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>												16. SOCIAL SECURITY NO. <b>Unascertainable</b>												17. INFORMANT <b>The Medical Record</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hemopericardium</b> 205X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Mycosis Fungoides</b> (c) <b>Hydrothorax</b> DUE TO cause last												INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>																																															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																																															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)																																															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)																																															
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 23, 1961</b> , to <b>January 29, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 29, 1962</b> , and that death occurred <b>11:30 AM</b> from the causes and on the date stated above.												22a. SIGNATURE <b>Paul P. Carbone MD</b>												22b. DATE SIGNED																																			
22c. PHYSICIAN'S NAME (Type) <b>Paul P. Carbone, M.D.</b>												22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>												22e. ADDRESS																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>												23b. DATE THEREOF <b>1/30/62</b>												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City, town or county) (State) <b>Sumerville Ga</b>																							
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co., 1400 Chapin St. NW Wash. DC</b>												25a. REC'D BY REGISTRAR <b>JAN 31 '62</b>												25b. REGISTRAR'S SIGNATURE <b>William S. Korman</b>																																			





00831 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00825

FOR STATE HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Medical Examiner's Office. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> c. LENGTH OF STAY IN b. <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. NAVAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Hanoverton</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hanoverton</b> d. STREET ADDRESS <b>P.O. Box 93</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HAROLD W HUK</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 13 19 62</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>CAU</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 14, 1941</b>	
9. AGE (In years last birthday) Months Days <b>20 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serviceman USN</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baden, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ARTHUR Conrad HUK Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Emerick</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NOX YES Oct 58 to date</b>		16. SOCIAL SECURITY NO. <b>290 34 6000</b>	
17. INFORMANT <b>WIFE: Mildred F. Huk, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Basal Skull Fracture</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute subdural hematoma</b> DUE TO (c) <b>Acute cerebral edema</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Interval between onset and death</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car, which apparently missed curve and turned over.</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:00 p.m. Jan. 12, 19 62</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Intersection of Rt. 2 &amp; 17</b>		20f. (City or town) (County) (State) <b>Spotsylvania Co., Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschiat</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. Broschiat</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>SHIPMENT</b>		22b. LOCATION (City, town, or country) (State) <b>Hanoverton, Ohio</b>	
23. FUNERAL DIRECTOR ADDRESS <b>W. W. Chambers Funeral Home, 1400 Chapin St. NW, Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Hanna</b>			



00832

CERTIFICATE OF DEATH

Reg. Dist. No. 00826

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Rural)</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>607 Hollywood Avenue</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring (Rural)</b>	
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>FRANCIS</b> Last <b>HUSTON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>16th</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22nd, 1895</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>6</b> Days <b>16</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Huston</b>		14. MOTHER'S MAIDEN NAME <b>Mary Keating</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Planche M. King, 1902--14th St. S.E. Wash. D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral arteriosclerosis</b> <b>3 3 4 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 2, 1961</b> to <b>Jan. 16, 1962</b> that I last saw the deceased alive on <b>Jan. 14, 1962</b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter K. Angevine</b>		DATE SIGNED <b>1/16/62</b>	
PHYSICIAN'S NAME (Type) <b>WALTER K. ANGEVINE</b>		ADDRESS (Street, city or town, state) <b>Washington 11, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/19/1962</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>	22d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers, Inc. Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 19 '62</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00833

00827

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bellevue</u> c. LENGTH OF STAY IN b. <u>11 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DC</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>472</u> d. STREET ADDRESS <u>422 Oakwood St. SE</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>H.</u> Last <u>Jacobi</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Month <u>Feb</u> Day <u>8</u> Year <u>1907</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LINE TYPE OPERATOR EVENING STAR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Charleston S.C.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Jacobi</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>578-09-8757</u>	
17. INFORMANT <u>Reina Jacobi</u>		Address <u>Wash DC 422 Oakwood St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Melanoma &amp; metastases</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>1</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 30, 1961</u> to <u>Jan 6, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 6, 1962</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>A. D. Bonifant</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. D. BONIFANT</u>		22d. ADDRESS <u>Farmington Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/9/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Bladensburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers CO.</u>		25a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
ADDRESS <u>517 11th St SE DC</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed and filed in the death record. The law also requires that the death certificate be signed by the attending physician and completed and filed in the death record. The law also requires that the death certificate be signed by the attending physician and completed and filed in the death record.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00834

00825

**1. PLACE OF DEATH**  
a. COUNTY MONTGOMERY MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA  
c. LENGTH OF STAY (In days) 5 days  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institutions; Residence before admission)  
a. STATE MARYLAND b. COUNTY MONTGOMERY  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE  
d. STREET ADDRESS ROCKVILLE PIKE

**3. NAME OF DECEASED** (Type or print) JOHNSON, MARY

**4. DATE OF DEATH** 1 20 1962

**5. SEX** FEMALE **6. COLOR OR RACE** Negro **7. MARRIED** ☐ NEVER MARRIED ☒ **8. DATE OF BIRTH** 10/22/93

**9. A. B. C. (In years)** 68 **IF UNDER 1 YEAR** 8 **IF UNDER 24 HRS.** 3  
Months Days Hours Min.

**10a. USUAL OCCUPATION** (One kind of work done during most of working life, even if retired) UNEMPLOYED **10b. KIND OF BUSINESS OR INDUSTRY** -

**11. BIRTHPLACE** (County & State or foreign entry) Montgomery County **12. CITIZEN OF WHAT COUNTRY?** UNITED STATES

**13. FATHER'S NAME** Asbury Johnson **14. MOTHER'S MAIDEN NAME** Lucinda Adams

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) no **16. SOCIAL SECURITY NO.** 218-30-369 **17. INFORMANT** Harry Johnson 611 Douglas Avenue Rockville, Md.

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) Broncho-pneumonia, acute  
491X DUE TO  
Conditions, if any, which gave rise to immediate cause (b) 5 days  
(a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sub-sternal Thyroid Hypertrophy; Anemia Severe

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☒

**20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (If either, NOTIFY MEDICAL EXAMINER.) ☐ **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 19.)

**20c. TIME OF INJURY** Month, Day, Year 19 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☐ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) **20f. (City or town)** (County) (State)

**21. I certify that (I) (this hospital) attended the deceased from** 1-15 1964 **to** 1-20 1962 **that (I) (we) last saw the deceased alive on** 1-19 1962 **and that death occurred at** 5:30 **PM, from the causes and on the date stated above.**

**22a. SIGNATURE** Clive E. Jackson **22b. DATE SIGNED** 1-20-62  
**22c. PHYSICIAN'S NAME** (Type) **22d. ADDRESS** 202 Martin Ln., Rockville, Md.

**23a. BURIAL, CREMATION, REMOVAL** (Specify) BURIAL **23b. DATE THEREOF** 1-23-62 **23c. NAME OF CEMETERY OR CREMATORY** Lincoln Park **23d. LOCATION** (City, town or county) (State) Rockville, Md.

**24. FUNERAL DIRECTOR'S SIGNATURE** Robert L. Swann **25a. REC'D BY REGISTRAR** MAN, 2 5 62 **25b. REGISTRAR'S SIGNATURE** Robert L. Swann

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

VII A15 (4)  
15M 9/60

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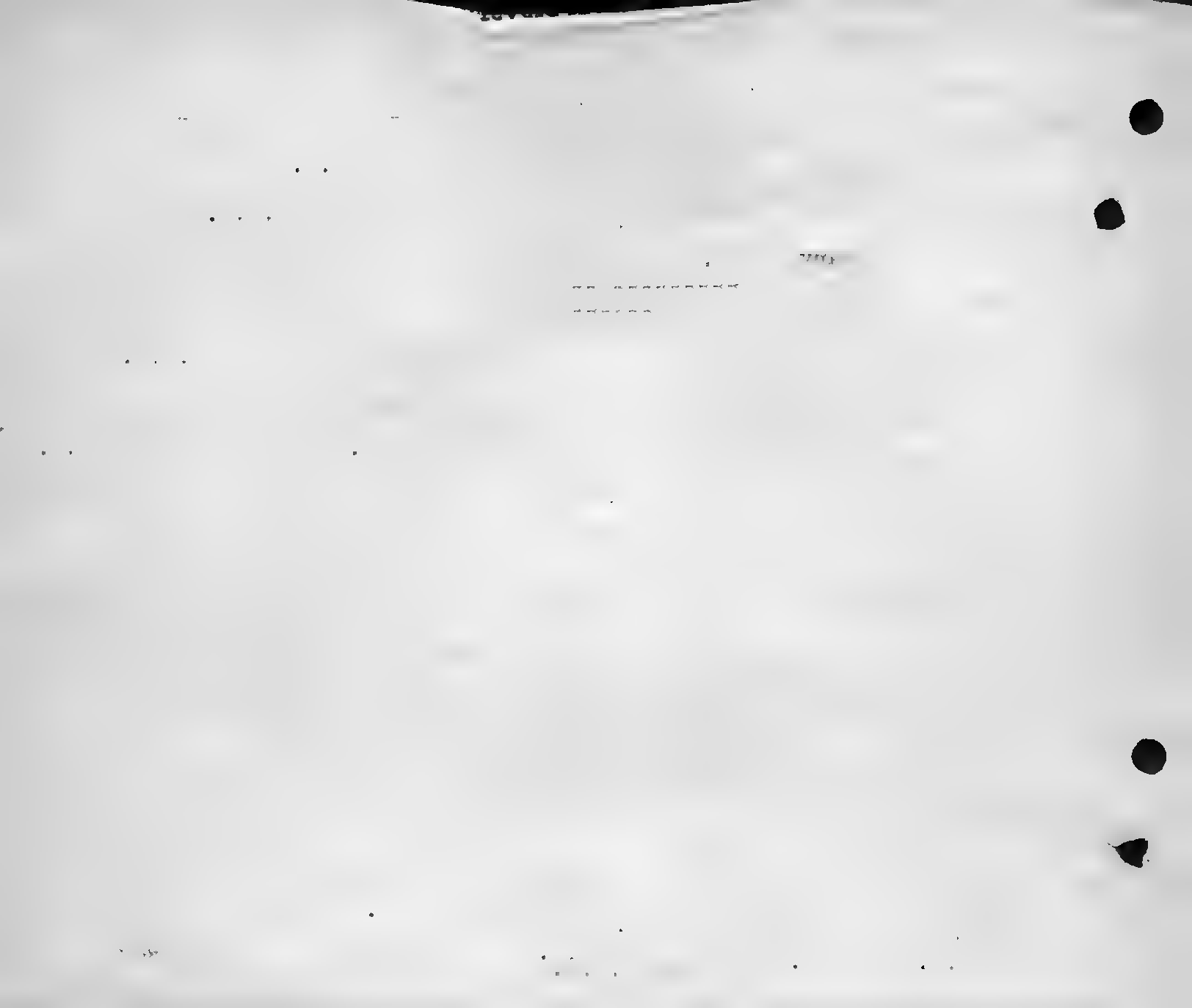


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00835  
00829  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>1401 21st Street, N.W. (?)</b>	
3. NAME OF DECEASED (Type or print) <b>Mary E. Johnson</b>		4. DATE OF DEATH <b>January 12 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/5/1867</b>
9. AGE (In years last birthday, yrs) <b>94</b>		10. IF UNDER 1 YEAR <b>IF UNDER 24 HRS.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>--- Vanderpoel</b>		14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Miss Patricia M. Sinnott-New York, N.Y.</b>		Address <b>325 West 45th St.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> e.m. p.m. Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 10</b> , 1962 to <b>Jan 12</b> , 1962, that (I) (we) last saw the deceased alive on <b>Jan 10</b> , 1962, and that death occurred at <b>8:40</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Eino Magi</b>		22b. DATE SIGNED <b>1-12-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>EINO MAGI</b>		22d. ADDRESS <b>918 Univ. Blvd. E, Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/15/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.-Arlington, Virginia</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00836

CERTIFICATE OF DEATH

Item 2 File 6507 2/13/62 iwk

00830

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on - Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Montgomery</u> <u>Walt Whitman Hotel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN lb <u>ENTERED</u> <u>12-2-61</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens San.</u>		d. STREET ADDRESS <u>13050 N. N. W. W.</u> <u>13050 N. N. W. W.</u> <u>800 Roeder Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>J.</u> Last <u>JONES</u>		4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-79</u>
9. AGE (In years lost birthday) <u>82</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railway express</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles L. Jones</u>		14. MOTHER'S MAIDEN NAME <u>SARAH F. Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Lillian Humphries</u>		Address <u>Spring, Md</u> <u>800 Roeder Rd. Silver</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertatic pneumonia and</u> <u>715X</u> DUE TO <u>Toxemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Decub. fur ulcers and malnutrition</u> DUE TO <u>4 months</u> (c) <u>4 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 21, 1961</u> to <u>Dec 15, 1962</u> that (I) (we) last saw the deceased alive on <u>Dec 14, 1962</u> and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above			
22a. SIGNATURE <u>R. Stephen Hu Bonting</u>		22b. DATE SIGNED <u>Dec 15, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. Stephen Hu Bonting</u>		22d. ADDRESS <u>3000 Denham Pl. NW Wash. 2, D.C.</u>	
23a. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-18-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Prince Georges Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Ziska</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>JAN 19 62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>322 Broadwood Drive</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>322 Broadwood Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RICHARD P. JONES</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>24</b> , Year <b>19 62</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 27, 1912</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months <b>49</b> Days <b>49</b>	
11. IF UNDER 24 HRS. Hours <b>49</b> Min. <b>49</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Julius Jones =</b>		14. MOTHER'S MAIDEN NAME <b>Grace A. Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW II</b>		16. SOCIAL SECURITY NO <b>Unknown</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item #2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary thrombosis</b> DUE TO (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>shock due to dehydration from vomiting</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>cirrhosis of liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>? years</b> <b>24 hr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 24, 1962</b> to <b>Jan. 24, 1962</b> ; that (I) (we) last saw the deceased alive on <b>Jan. 24, 1962</b> and that death occurred at <b>5 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>G. Bowditch Hunter, Jr.</b> M.D.		22b. DATE SIGNED <b>Jan 25, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>G. Bowditch Hunter, Jr.</b>		22d. ADDRESS <b>809 Viers Mill Rd. Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/29/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 1 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	



00838

CERTIFICATE OF DEATH

Reg. Dist. No. 00832

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8001 EASTERN AVE APT. 102</b>		e. STREET ADDRESS <b>8001 EASTERN AVE APT. 102</b>	
3. NAME OF DECEASED (Type or print) First <b>GUSTAVE</b> Middle <b>A.</b> Last <b>KAISER</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>3</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 18, 1889</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BUILDER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BUILDING</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ISAAC T. KAISER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>MRS. FRANCES MARGOLIS</b> Address <b>1444 Buck CR. Ford Rd N.W.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>ARTERIO-SCLEROTIC HEART DISEASE</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO (c) <b>CEREBRAL THROMBOSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 HR.</b> <b>8 YRS.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL THROMBOSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1951</b> to <b>JAN. 3</b> , 1962 that I last saw the deceased alive on <b>DEC. 30</b> , 1961, and that death occurred at <b>6:30</b> P. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>5410 CONNECTICUT AVE</b> DATE SIGNED <b>1-3-62</b>			
ACTUAL SIGNATURE <b>SALL ZUKERMAN</b> M.D.		DATE SIGNED <b>1-3-62</b>	
PHYSICIAN'S NAME (Type) <b>SALL ZUKERMAN, M.D.</b>		ADDRESS <b>WASHINGTON 15, D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-5-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HILLSIDE M.D.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS</b> ADDRESS <b>3501-14th St. NW</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 8 '62</b>	24b. REGISTRAR'S SIGNATURE <b>W. S. HARRIS</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be released by the hospital or attending physician.





CERTIFICATE OF DEATH

Reg. Dist. No. 00833

00839

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVERSPRING</b> c. LENGTH OF STAY IN 1b <b>FAIRLAND NURSING HOME</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>/SILVER SPRING Washington, D. C.</b> d. STREET ADDRESS <b>1336 Jonquil St. N.W.</b> <b>FAIRLAND NURSING HOME</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MOLLIE</b> First Middle Last <b>KATZ</b>		4. DATE OF DEATH Month Day Year <b>JANUARY 2, 1962 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1867</b>	9. AGE (in years last birthday) <b>94</b> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>000</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>ISAAC SANDLER</b>			
14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>HARRY KATZ 1336 JONQUIL ST., N.W.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Congestive heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ast. (b) <b>Hypertension</b> DUE TO <b>Cardiac hypertrophy</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>20 yrs</b> <b>20 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>		(County) <b>---</b>		(State) <b>---</b>	
21. I certify that I attended the deceased from <b>Dec 31, 1961</b> to <b>Jan 2, 1962</b> , that I last saw the deceased alive on <b>Jan. 2, 1962</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3311-16. NW. Wash. DC</b> DATE SIGNED <b>Jan 8 '62</b>					
ACTUAL SIGNATURE <b>Dr. John E. Virnstein</b>		PHYSICIAN'S NAME (Type) <b>Dr. John E. Virnstein</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN. 4, 1962</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OSHEV SHOLOM-TALMUD TORAH CEM. WASHINGTON, D.C.</b>	
22d. LOCATION (City, town, or county) <b>WASHINGTON, D.C.</b>		(State) <b>---</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS 3501 14th St.</b>		ADDRESS <b>---</b>		24a. REC'D BY REGISTRAR <b>---</b>	
24b. REGISTRAR'S SIGNATURE <b>---</b>		24c. REGISTRAR'S SIGNATURE <b>---</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00840

00834

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7508 BenAvon Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Charles N. Keating, Sr.</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>12/24/03</u> 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>A.I.D.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Kansas</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Keating</u> 14. MOTHER'S MAIDEN NAME <u>Ellen Harrington</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO <u>None</u> 17. INFORMANT <u>wife-Jean M. Keating</u> Address <u>same as above</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic insufficiency</u> DUE TO (b) <u>Massive Metastatic Carcinoma,</u> DUE TO (c) <u>Primary site, undet</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 w</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> Hour a.m. <u>  </u> p.m. <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u> 20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 1959</u> to <u>Jan 26, 1962</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> <u>1962</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Michel M. Healy</u> M.D. 22b. ADDRESS <u>5523 Trent St., Chevy Chase, Md.</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Michel M. Healy</u>		22d. DATE SIGNED <u>1/26/62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-29-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u> 23d. LOCATION (City, town or county) <u>Montgomery County, Md.</u> (State) <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>1 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00841

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00835

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 Day</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>2 Namassin Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Zalman Abraham Kekst</b>		4. DATE OF DEATH <b>January 3, 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>July 27, 1931</b>	9. AGE (In years last birthday) <b>30</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Jacob Kekst</b>	
14. MOTHER'S MAIDEN NAME <b>Anna Lewensohn</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>006-30-3506</b>		17. INFORMANT <b>The Medical Records The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pericarditis with massive pericardial effusion</b> DUE TO (b) <b>Gaucher's disease</b> DUE TO (c) <b>30 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>January 3, 1962</b> to <b>January 3, 1962</b> that (I) (we) last saw the deceased alive on <b>January 3, 1962</b> , and that death occurred at <b>6:20 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Karl Engelman</b>		22b. DATE SIGNED <b>1/4/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>KARL ENGELMAN, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Jan. 4, 1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID CEMETERY</b>	23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry H. Bear</b>		25a. REC'D BY REGISTRAR <b>JAN 5 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
00842  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Rainier</u>	
c. LENGTH OF STAY IN 1b <u>1 day</u>		d. STREET ADDRESS <u>3360 CHILLUM RD.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sund Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>TRACEY ANNE Kelley</u> First Middle Last <u>Baby Girl</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OF HAIR <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-8-62</u>	
9. AGE (In years last birthday) <u>0</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
12. BIRTHPLACE (State or foreign country) <u>USA.</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
14. FATHER'S NAME <u>Richard Kelley</u>		15. MOTHER'S MAIDEN NAME <u>BARBARA WYATT</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. <u>Address</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPERBILIRUBINEMIA</u> 77 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ABO BLOOD INCOMPATABILITY</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>29 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>1-8-1962</u> to <u>1-9-1962</u> that (1) (we) last saw the deceased alive on <u>1-9-1962</u> and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Mary K. L. Sartwell, M.D.</u> M.D.		22b. DATE SIGNED <u>1-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Mark K. L. Sartwell, M.D.</u>		22d. ADDRESS <u>6811 Riggs Rd., Hyattsville, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-12-62</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>mt Olney Cem.</u>		23d. LOCATION (City, town, or county) <u>Wash.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis Collins</u> ADDRESS <u>3821-14th St. N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE</u> <u>15 '62</u>	
25b. REGISTRAR'S SIGNATURE			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

FOR STATE  
HEALTH DEPT.

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, write RURAL and give nearest town) <u>Burtonsville</u>			
c. LENGTH OF STAY IN IS <u>10 yrs</u>				d. STREET ADDRESS <u>3020 Maple Hill Rd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>3020 Maple Hill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Middle</u> <u>Last</u> <u>Lorenzo Charles Kidwell</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>26</u> Year <u>1962</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-15-82</u>		9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Melvin Kidwell</u>		14. MOTHER'S MAIDEN NAME <u>Catharine Harrison</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-18-2170</u>	
17. INFORMANT <u>Melvin A. Kidwell (son)</u>		Address <u>Stim 2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (c), stating the underlying cause last. DUE TO <u>sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>History of previous heart disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <u>Burtonsville Maryland</u>				DATE SIGNED <u>1-26-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-29-62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Burtonsville Union Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Burtonsville Maryland</u>	
23. FUNERAL DIRECTOR <u>RO Jiska</u> 8434 ADDRESS <u>Georgia Avenue</u>		24a. REC'D BY REGISTRAR <u>JAN 29 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Wm S. Hines</u>		24c. REGISTRAR'S SIGNATURE	
Varner E. Pumphrey, Inc. Silver Spring, Maryland				DATE			

OR ATTENDING PHYSICIAN: The law requires that the death certificate be  
may be retained by the hospital or attending  
DIRECTOR: After this certificate

After this certificate

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

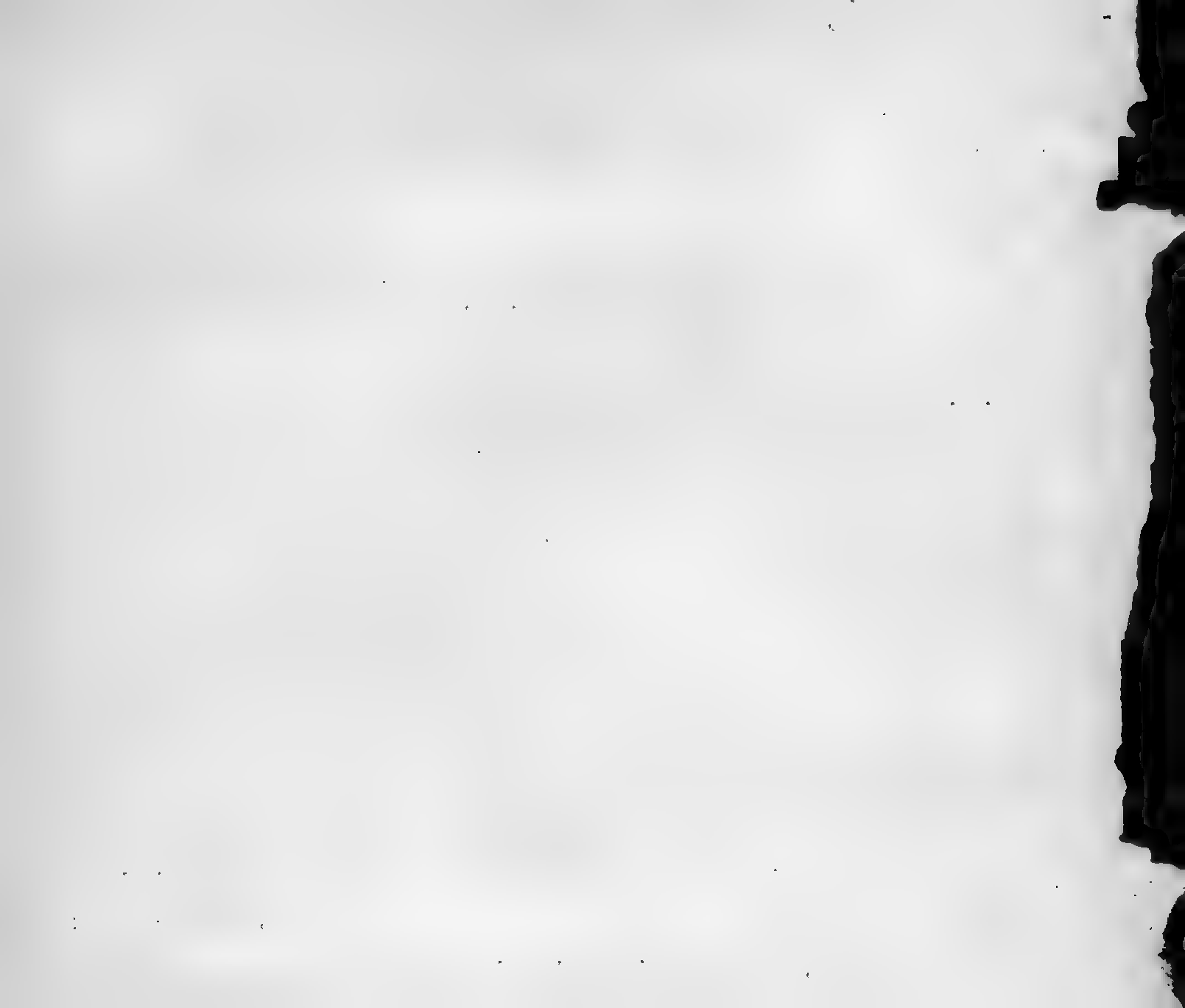
00844

00838

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 Baltimore Road</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>09 Rockville</u> d. STREET ADDRESS <u>300 Baltimore Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>FOREST</u> Middle <u>KING</u> Last <u>KING</u> <b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>13</u> Year <u>1962</u>		<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Dec. 31, 1893</u> <b>9. AGE</b> (In years last birthday) <u>68</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farming</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>E. D. King</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Gertrude Lawson</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>Pearl E. King-Item # 2</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>coronary arteriosclerosis</u> (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>20</u> <u>Indef.</u> <u>Indef.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary Heart Failure</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20c. TIME OF INJURY</b> Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> e.m. <u>  </u> p.m. <u>  </u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County, (State) <u>  </u>	
<b>21 I certify that (I) (this hospital) attended the deceased from</b> <u>1/11/62</u> <b>to</b> <u>1/13/62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/11/62</u> <b>and that death occurred at</b> <u>PRAM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Stephen N. Jones M.D.</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen N. Jones</u>		<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22d. ADDRESS</b> <u>809 Viers Mill Road, Rockville, Md.</u> <b>22b. DATE SIGNED</b> <u>1/13/62</u>	
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1/15/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Rockville, Maryland</u>		<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 15 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>S. Krawe</u>	

MEDICAL CERTIFICATION

TO BE COMPLETED BY PHYSICIAN. This certificate has been signed by the attending physician and completely detached for use as the burial-transit permit. Then please remove carbon papers. As directed, page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
00845  
CERTIFICATE OF DEATH  
00839

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>DISTRICT OF COLUMBIA</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> 47X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KENSINGTON GARDENS</b>		d. STREET ADDRESS <b>2737 CATHEDRAL AVE., N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY C KINNEY</b>		4. DATE OF DEATH Month Day Year <b>JAN 12 19 62</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 19, 1877</b>
9. AGE (In years last birthday) yrs <b>84</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>LOUISE C. KATLIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>UNKNOWN UNKNOWN</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>A.G. NICHOLS, JR.</b>		725 15th ST. N.W. <b>WASHINGTON, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4-20 Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>20 yrs.</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1951</b> 19 to <b>1/12</b> 19 <b>62</b> that (I) (we) last saw the deceased alive on <b>1/12</b> 19 <b>62</b> and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>John W. Latimer, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>John W. Latimer, Jr.</b>		22d. ADDRESS <b>1728 Mass Ave N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation Jan 13-1962</b>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <b>Sedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland P.H. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Nicholas, Jr.</b>		25. REG'D BY REGISTRAR <b>JAN 15 '62</b>	
ADDRESS <b>1750 Pa Ave Wash, D.C.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Harris</b>	



00846

## CERTIFICATE OF DEATH

Reg. Dist. No. 111840

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 31</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BEL PRE NURSING HOME</b>				d. STREET ADDRESS <b>11119 NORLEE DRIVE</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HILDA</b> Middle <b>KLINE</b> Last <b>KLINE</b>				4. DATE OF DEATH Month <b>JAN.</b> Day <b>22,</b> Year <b>1962 19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 4, 1881</b>		9. AGE (In years last birthday) <b>80 yrs.</b>	IF UNDER 1 YEAR: IF UNDER 24 HRS: Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALAN MOSTOW</b>				14. MOTHER'S MAIDEN NAME <b>GALE SUSAN ---</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>---</b>		INFORMANT Address <b>MEYER BARWESS-11119 NORLEE DR., S.S., MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>22</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c) PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis past 25 years.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>25 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1945</b> , 19 <b>---</b> , to <b>JAN. 22, 1962</b> that I last saw the deceased alive on <b>JAN. 21, 1962</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Samuel Dessoff</b> M.D. <b>1302-1850 M. Wash. C.D.C. 1/23/62</b> PHYSICIAN'S NAME (Type) <b>DR. SAMUEL DESSOFF</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-62</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ELESAVETGRAD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS</b>				ADDRESS <b>3501 14th St.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 25 '62</b>	
				24b. REGISTRAR'S SIGNATURE <b>C. J. P. Thomas</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be relayed by the hospital or attending physician to the funeral director. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

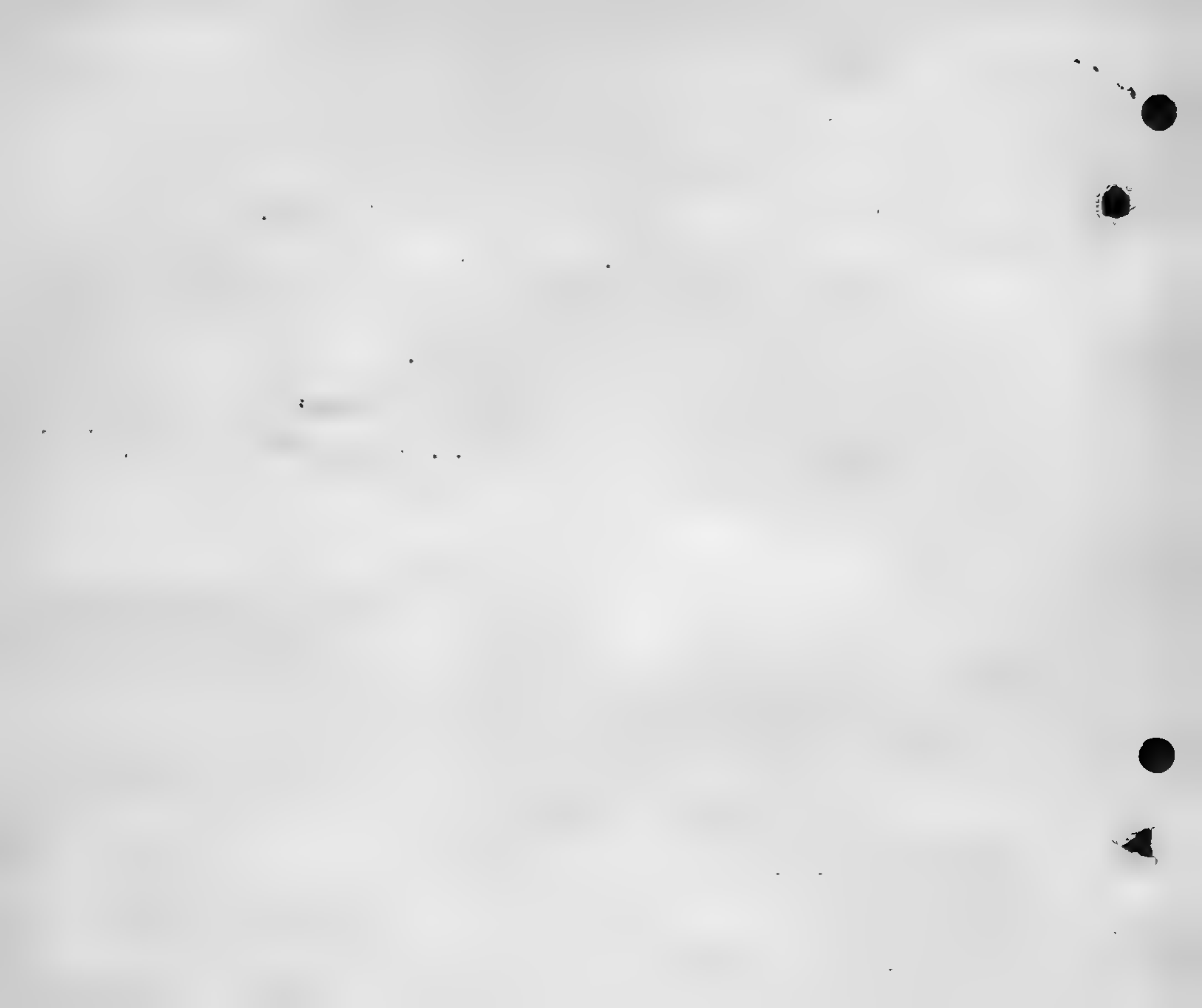
VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00847

00841

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1233 Simmons Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lucille</u> Middle <u>D.</u> Last <u>Koshnick</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>4</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/15/88</u> <b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Nurse</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Mich.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>Joseph Koshnick</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Greene</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>WW 1 yes</u> <b>16. SOCIAL SECURITY NO.</b> <u>None</u> <b>17. INFORMANT</b> <u>cousin, G.L. Healey- 13103 Arctic Ave.,</u> Address <u>Rockville, Md.</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Congestive heart failure</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of statement 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>Rockville, Md.</u>		<b>20g. (County)</b> <u>Montgomery</u>	
<b>20h. (State)</b> <u>Md.</u>		<b>20i. (Country)</b> <u>USA</u>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Oct 1959</u> <b>to</b> <u>Jan 1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1-3-1962</u> <b>and that death occurred at</b> <u>10:30 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>W. G. Hall</u> M.D. <b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. G. Hall</u>		<b>22b. DATE SIGNED</b> <u>1-4-62</u> <b>22d. ADDRESS</b> <u>615 W. MONTGOMERY AVE</u> <u>Rockville, Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/8/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Arlington, Virginia</u> (State)	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 9 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>J. L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>127 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Takoma Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <b>January</b>		Day <b>27</b>		Year <b>19 62</b>	
3. NAME OF DECEASED (Type or print) <b>ALBERT WINSTON KRAFT</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1909</b>	
9. AGE (In years last birthday) <b>53</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumber</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philip H. Kraft</b>		14. MOTHER'S MAIDEN NAME <b>Anna S. Cardozo</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes WW II &amp; Korean</b>		16. SOCIAL SECURITY NO. <b>Mrs. Lucille M. Kraft</b>		17. INFORMANT (Wife) <b>same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>193.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last, DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>ASTROCYTOMA</b>		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>September 23 1961 to January 27, 1962</b>		20g. (County) <b>MD</b>		20h. (State) <b>MD</b>		21. I certify that (this hospital) attended the deceased from... saw the deceased alive on... and that death occurred at... from the causes and on the date stated above, <b>January 27, 1962</b> at <b>9:36 PM</b>		22a. SIGNATURE <b>C. W. Bramlett</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>C. W. Bramlett LCDR MC USN</b>	
22b. ADDRESS <b>U.S. Naval Hospital, Bethesda, Maryland</b>		22d. DATE SIGNED <b>28 January 1962</b>		23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-31-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	
23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>		23e. ADDRESS <b>Washington, D.C.</b>		23f. REC'D BY REGISTRAR <b>Robert A. Mattingly</b>		23g. REGISTRAR'S SIGNATURE <b>Robert A. Mattingly</b>		23h. DATE <b>AN 30 '62</b>	



**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00240

111845

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		b. COUNTY <u>Montgomery</u>	
c. LENGTH OF STAY IN 1b <u>Since Jan 17 1962</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		d. STREET ADDRESS <u>11708 Caplinger Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Sarah Elizabeth Kuykendall</u>		4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 - 6 - 1927</u>	
9. AGE (In years, if UNDER 1 YEAR; last birthday) <u>34</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>	
13. FATHER'S NAME <u>Amos Adams</u>		14. MOTHER'S MARRIAGE NAME <u>Susan Hollenback</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FRANK M. DUNCAN</u>		18. ADDRESS <u>11708 Caplinger Rd. S.S. Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Bronchopneumonia, Rt Lung</u>		20. INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
21. CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) DUE TO (c)		22. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic Cardiovascular Disease</u>	
23. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
25. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
27. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		28. (City or town) (County) (State)	
29. I certify that (I) (this hospital) attended the deceased from <u>Jan 17, 1962</u> to <u>Jan 27, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 26, 1962</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above		30. DATE SIGNED <u>Jan 27, 1962</u>	
31. SIGNATURE <u>Gene U. Cohen, M.D.</u>		32. ADDRESS <u>1106 SPRING ST. SILVER SPRING MD.</u>	
33. PHYSICIAN'S NAME (Type) <u>GENE U. COHEN M.D.</u>		34. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
35. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		36. DATE THEREOF <u>1-29-62</u>	
37. NAME OF CEMETERY OR CREMATORY <u>Greenwell Cemetery</u>		38. LOCATION (City, town or county) (State) <u>MINERAL COUNTY W. Virginia</u>	
39. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		40. ADDRESS <u>SILVER SPRING, MD</u>	
41. REC'D BY REGISTRAR <u>JAN 31 '62</u>		42. REGISTRAR'S SIGNATURE <u>Charles S. Hume</u>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7.61



00850

111634

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i>		c. LENGTH OF STAY IN 1b <i>4 1/2 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Kensington Gardens SAN.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C.</i>	
f. STREET ADDRESS <i>7130 - 8th St N.W.</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <i>Celia</i> Middle <i>LACHMAN</i> Last <i>LACHMAN</i>		4. DATE OF DEATH Month <i>1</i> Day <i>3</i> Year <i>1962</i>	
5 SEX <i>F</i>	6 COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>86</i> yrs
9 AGE (In years last birthday) <i>86</i> yrs		IF UNDER 1 YEAR Months <i>8</i> Days <i>3</i> Hours <i>19</i> Min <i>62</i>	IF UNDER 24 HRS Months <i>8</i> Days <i>3</i> Hours <i>19</i> Min <i>62</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Austria</i>	
11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Nathan Ring</i>		14. MOTHER'S MAIDEN NAME <i>Not known</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT <i>Mrs Gertrude Katz - same</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular accident - hypertensive</i> DUE TO <i>710 yrs</i> (b) <i>Cerebral arteriosclerosis and</i> DUE TO <i>Arteriosclerotic hypertensive cardiovascular disease</i> (c) <i>Arteriosclerotic hypertensive cardiovascular disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12-24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>19</i>		WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>o. m.</i> <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <i>March 1957</i> to <i>1-3-1962</i> , that (I) (we) last saw the deceased alive on <i>1-2-1962</i> and that death occurred at <i>3 PM</i> , from the causes and on the date stated above			
22a. SIGNATURE <i>Jason Geiger, M.D.</i>		22b. DATE SIGNED <i>1-3-62</i>	
22c. PHYSICIAN'S NAME (Type) <i>JASON GEIGER, M.D.</i>		22d. ADDRESS <i>1112 SPRING STREET SILVER SPRING, MD.</i>	
23a. DATE OF REMOVAL (Specify) <i>March 1-5-62</i>		23b. DATE THEREOF <i>March 1-5-62</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>		23d. LOCATION (City, town, or county) (State) <i>Balto Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS <i>2100 E. 1st Ave</i>	
25a. REC'D BY REGISTRAR <i>JAN 8 '62</i>		25b. REGISTRAR'S SIGNATURE <i>J. S. King</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 00940

00851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6517 Oakwood Road</u>		1. d. STREET ADDRESS <u>6517 Oakwood Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>La Croix</u>		4. DATE OF DEATH Month Day Year <u>January 24 1962</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-61</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR <u>8</u> Months <u>18</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jean Claude La Croix</u>		14. MOTHER'S MAIDEN NAME <u>Rosemary Mc Lermott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute interstitial pneumonitis, viral</u> DUE TO <u>472X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute congestion, larynx and trachea, from</u> DUE TO (c) <u>Inhalation, stomach contents</u>		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute hypoxia, manifested by, petechiae in thymus, brain and heart</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1-22</u> , 19 <u>62</u> , to <u>1-24</u> , 19 <u>62</u> , that I last saw the deceased alive on <u>1-22</u> , 19 <u>62</u> , and that death occurred at <u>2:10 P.</u> M., from the causes and on the date stated above.		
ACTUAL SIGNATURE <u>W. Fleet Kuchta</u>	ADDRESS (Street, city or town, state) <u>5000 Reno Rd. NW</u>	DATE SIGNED <u>3-22-62</u>
PHYSICIAN'S NAME (Type) <u>William F. Luckett M.D.</u>	<u>5000 Reno Rd. NW Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>1/27/62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>
22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert R. Humphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 27 '62</u>
		24b. REGISTRAR'S SIGNATURE <u>Dr. Geo E. Kneass</u>

Film #204- 3/11 - ORIGINAL CERTIFICATE

ONLY ADD TO NAME OF MEINDA - FAMILY

11 -

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 could be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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00852

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00845

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crisfield</b> <b>19X2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WOODLAND NURSING HOME</b>		d. STREET ADDRESS <b>Jacksonville Rd.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>ETHEL</b> Middle <b>PRISCILLA</b> Last <b>LAIRD</b>		4 DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>1962</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Sept. 26, 1883</b>
9. AGE (In years last birthday) yrs <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Crisfield, Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Thomas Daugherty</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Catherine Pope</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b> <b>None</b>		16 SOCIAL SECURITY NO. <b>None</b>	
17 INFORMANT <b>Mrs. Charlton Marshall, Crisfield, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal Insufficiency</b> <b>4 + 23.1</b> DUE TO <b>Generalized Atherosclerosis</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Artery Disease; Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>672 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <b>July 9, 1961</b> to <b>Jan 1, 1962</b> that (I) (we) last saw the deceased alive on <b>Dec 30 1961</b> , and that death occurred at <b>3:14 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Bernard A. Fitzgerald</b>		22b. DATE SIGNED <b>1-1-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>BERNARD A. FITZGERALD</b>		22d. ADDRESS <b>217 UNIVERSITY BLVD E, S.S., Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/3/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Crisfield, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00853 011446

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Olney, Md.</u> c. LENGTH OF STAY IN b. <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brooke Grove Foundation</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9815 Singleton Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>El Nora Blythe Lamiman</u> First Middle Last		4. DATE OF DEATH <u>Jan. 2 1962</u> Month Day Year	
5. SEX <u>Female</u> <u>White</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>May 3, 1876</u> 8. DATE OF BIRTH <u>85</u> yrs. <u>85</u> yrs.		9. AGE (In years, last birthday) <u>85</u> yrs. <u>85</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>8</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Salt Lake City, Utah</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter Christianesen</u> 14. MOTHER'S MAIDEN NAME <u>Sophia Christianesen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u> (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Hospital Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>443X</u> IMMEDIATE CAUSE (a) <u>Branchopneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Cerebrovascular Accident</u> (c) <u>Hypertensive Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>1 wk</u> <u>1 mo</u> <u>1 yr</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY: Month, Day, Year <u>19</u> hour <u>19</u> e.m. <u>19</u> p.m. 20d. INJURY OCCURRED: White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>7/27</u> <u>1961</u> to <u>1/2</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>12/31</u> <u>1961</u> , and that death occurred at <u>3:30 p.m.</u> from the causes and on the date stated above		22a. SIGNATURE <u>C. H. Higdon</u> 22c. PHYSICIAN'S NAME (Type) <u>C. H. Higdon</u> 22b. DATE SIGNED <u>1/2/62</u> 22d. ADDRESS <u>Safety Springs, Md.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u> 23b. DATE THEREOF <u>1-6-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Zanesville, Ohio</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u> 25a. REC'D BY REGISTRAR <u>JAN 5 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00854  
CERTIFICATE OF DEATH  
02075

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy Rt. # 3</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adamstown</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Airy Rt. # 3</u>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Webster Lee-Sr.</u>		4. DATE OF DEATH Month Day Year <u>January 30, 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-13-1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>81</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
13. FATHER'S NAME <u>William F. Lee</u>		14. MOTHER'S MAIDEN NAME <u>Susan Ball</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year and date of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Daniel W. Lee, Jr.</u>		Address <u>Adamstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cancer of the rectum with generalized metastases</u> 154 X Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from <u>February 10, 1957</u> to <u>January 30, 1962</u> that (I) (we) last saw the deceased alive on <u>January 26, 1962</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James P. Kerr</u>		22b. DATE <u>1/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr</u>		22d. ADDRESS <u>Damascus, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Dailey and Son</u>		25a. REC'D BY REGISTRAR <u>11:00 7 '62</u>	
ADDRESS <u>Frederick, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>C. E. H. H. H.</u>	





TO HOSPITAL OR FUNERAL HOME: This certificate is to be filled out by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MD 10-10-60  
00855

00847

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 10.</u> d. STREET ADDRESS <u>1680 Irving Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Edith Yates</u>		e. IS RESIDENCE ON A FMS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. SEX <u>female</u>		5. DATE OF BIRTH <u>December 8, 1889</u>	
6. COLOR OR RACE <u>white</u>		6. DATE OF DEATH <u>January 13, 1962</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7. AGE (In years last birthday) <u>74</u> yrs.	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Internal Revenue Service</u>		8. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>	
9. FATHER'S NAME <u>Harry Lee</u>		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		11. SOCIAL SECURITY NO. <u>578-46-6457</u>	
12. CAUSE OF DEATH (Enter only one cause per line for a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Block - complete</u> Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Disease</u> (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		12. INTERVAL BETWEEN ONSET AND DEATH <u>5-days</u> <u>5-years</u> <u>2-years</u>	
13. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		13. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
14. TIME OF INJURY Month, Day, Year <u>19</u>		14. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
15. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1962</u> to <u>Jan 13, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 12, 1962</u> and that death occurred at <u>3:25 PM</u> from the causes and on the date stated above		15. (City or town) (County) (State)	
16. SIGNATURE <u>Robert A. Hare</u>		16. DATE SIGNED <u>1/13/62</u>	
17. PHYSICIAN'S NAME (Type) <u>Robert A. Hare</u>		17. ADDRESS <u>1600 Carroll Ave., T. Park, Md.</u>	
18. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		18. DATE THEREOF <u>1/15/1962</u>	
19. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		19. LOCATION (City, town or county) (State) <u>Haleville, New Jersey</u>	
20. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		20. ADDRESS <u>2901 14th St., N.W.</u>	
21. REC'D BY REGISTRAR <u>JAN 15 '62</u>		21. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00856

00848

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND		<b>2 USUAL RESIDENCE</b> (Where deceased lived If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>22 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charles</u> Middle <u>Lemke</u> Last <u>Lemke</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>9</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/94</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>	11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>Hosp Records</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4-20-1 DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-8</u> 19 <u>62</u> to <u>1-9</u> 19 <u>62</u> that (I) (we) lost saw the deceased alive on <u>1-9</u> 19 <u>62</u> and that death occurred at <u>1600</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>1-9-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Horace Bernton</u>		22d. ADDRESS <u>47438 Bradley Blvd - Beth. Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-16-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 18 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>		25c. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Payment may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00857

11/10/62

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Shipman</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grover Carlton Ligon</b>		4. DATE OF DEATH Month Day Year <b>1 10 1962</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/8/1984</b>
9. AGE (In years last birthday) <b>77</b>		10. IF UNDER 1 YEAR Months Days <b>10 10</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Daniel Ligon</b>		14. MOTHER'S MAIDEN NAME <b>Julia Conner</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Office Records</b>		Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO <b>Cardiorespiratory Failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease and</b> (e), stating the underlying cause last, (c) <b>Pulmonary Fibrosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>Arteriosclerotic Aneurysm, Aorta - Lericq's Syndrome</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.			
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		21d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/9/62</b> to <b>11/10/62</b> that (I) (we) last saw the deceased alive on <b>11/9/62</b> and that death occurred <b>11/10/62</b> from the causes and on the date stated above			
22a. SIGNATURE <b>C. H. Ligon</b>		22b. DATE SIGNED <b>11/10/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Ligon</b>		22d. ADDRESS <b>Olney, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1-13-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Family Burial Grounds</b>		23d. LOCATION (City, town or county) (State) <b>Shipman, Nelson, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		25c. DATE <b>JAN 15 '62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00858

00850

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>12211 MIDDLE ROAD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTG.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> d. STREET ADDRESS <b>12211 MIDDLE ROAD</b>	
3. NAME OF DECEASED (Type or print) <b>MYER</b>		4. DATE OF DEATH <b>JAN. 1 1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN-11-1898</b>
9. AGE (In years last birthday) <b>63 yrs.</b>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING SUPPLY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>DC.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS LIPKIN (Dec.)</b>		14. MOTHER'S MAIDEN NAME <b>RACHEL (Dec.)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>59-03-6078</b>	
17. INFORMANT <b>ANNIE D. LIPKIN</b>		Address <b>(same as 2 above)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Humanage from lungs</b> DUE TO (b) <b>Metastatic lesions of lungs</b> DUE TO (c) <b>Carcinoma of lung - left</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3/15</b> 19 <b>58</b> to <b>1-1</b> 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>61</b> , and that death occurred at <b>11:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Francis F. Richardson</b>		22b. DATE SIGNED <b>1/1/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>F. X. RICHARDSON</b>		22d. ADDRESS <b>1141 Viers Mill Rd. Wheaton MD.</b>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>	23b. DATE/THEREOF <b>1/3/1962</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CEM</b>	23d. LOCATION (City, town or county) (State) <b>SUITLAND, MD.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Goodley Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 3 '62</b>	
ADDRESS <b>4217 9th Ave</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00859

00851

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY <u>N 15</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if not in hospital; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Point (Rural)</u> d. STREET ADDRESS <u>6772</u>	
3. NAME OF DECEASED Type or print) <u>CATHERINE</u> <u>Janet</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>22</u> <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1884</u>
9. AGE (If years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bryantown, Charles Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Justin Miles Dyer</u>		14. MOTHER'S M maiden name <u>Mary Green</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Cecelia L. Miller-Daughter</u>		Address <u>9411 Warner St., Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE HEART DISEASE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEMI-CLINICAL</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-5</u> 19 <u>61</u> , to <u>1-22</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1-22</u> 19 <u>62</u> , and that death occurred at <u>10:40</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Heinrich Fowden</u>		22b. DATE SIGNED <u>1-22-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Heinrich Fowden</u>		22d. ADDRESS <u>5206 Norway Dr. Chevy Chase, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-24-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Ghost</u>		23d. LOCATION (City, town or county) (State) <u>Isslewood</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Inc</u>		25. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
25a. REC'D BY REGISTRAR <u>JAN 26 '62</u>		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR HOSPITAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00860

00852

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> <b>135 days</b> c. LENGTH OF STAY IN b. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Vermont</b> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Peru</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Jane (n) MacFarlane</b> First Middle Last <b>4. DATE OF DEATH</b> <b>January 5, 1962</b> Month Day Year		<b>5. SEX</b> <b>Female</b> <b>6. COLOR OR RACE</b> <b>Caucasian</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>December 13, 1897</b> <b>64</b> yrs. 9. AGE (In years last birthday) <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Boston, Mass.</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James McKean</b> <b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> <b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <b>HUS: Scott B. MacFarlane, Same as #2</b> Address	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> <b>175.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Metastatic Carcinoma of the ovary</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>19</b> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> Home, farm, factory, street, office bldg., etc. <b>20f. (City or town)</b> (County) (State)		<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Aug. 24, 1961</b> to <b>Jan. 5, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 5, 1962</b> , and that death occurred <b>5:45AM</b> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <b>Joel S. Goodwin</b> <b>22b. DATE SIGNED</b> <b>January 5, 1962</b> <b>22c. PHYSICIAN'S NAME</b> (Type) <b>JOEL S. GOODWIN LT MC USN</b> <b>22d. ADDRESS</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>		<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>1-5-62</b> <b>23b. DATE THEREOF</b> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Cemetery</b> <b>23d. LOCATION</b> (City, town or county) (State) <b>Suitland, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>ROBERT A. POMPHREY</b> <b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Harris</b> <b>Funeral Home, Bethesda, Md.</b> <b>DATE</b> <b>JAN 8 '62</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

### CERTIFICATE OF DEATH

00861

00853

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> <span style="float: right;">15 min.</span> c. LENGTH OF STAY IN IT d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Virginia</u> <span style="float: right;">b. COUNTY</span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Falls Church</u> d. STREET ADDRESS <u>1736 Arlington Blvd.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Joseph Thomas Mackassay</u> First Middle Last <b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 31, 1887</u> <b>9. AGE</b> (In years last birthday) <u>74</u> yrs. <b>IF UNDER 1 YEAR</b> <u>Jan. 25</u> <b>IF UNDER 24 HRS.</b> <u>19 62</u> Months Days Hours Min.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Wisconsin</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Thomas Mackassay</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Honora Donahue</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Unknown</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>S. Daugh: Miss Margaret Vincent, Same as #2</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dessecting aneurysm of the descending aorta</u> DUE TO (b) <u>451X</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u>451X</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>None</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Hour a.m. <u>19</u> Month, Day, Year <u>19 62</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> Home, farm, factory, street, office bldg., etc. <u>None</u> <b>20f. City or town</b> <u>None</u> <b>(County)</b> <u>None</u> <b>(State)</b> <u>None</u>			
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 25, 1962</u> , to <u>January 25, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 25, 1962</u> , and that death occurred at <u>8:10 PM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>W. F. Warrender</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>W. F. WARRENDER LT MC USN</u>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> <b>22b. DATE SIGNED</b> <u>Jan. 26, 1962</u> <b>22d. ADDRESS</b> <u>U. S. Naval Hospital, Bethesda, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1-29-62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u> <b>23d. LOCATION</b> (City, town or county) <u>Arlington, Virginia</u> <b>(State)</b> <u>Virginia</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Rinaldi</u> <b>25a. REC'D BY REGISTRAR</b> <u>Jan 30 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

2

TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be obtained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00362

001854

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN b <b>4 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b> d. STREET ADDRESS <b>WASHINGTON GROVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE V. BEALL</b> First Middle Last		4. DATE OF DEATH <b>1 10 1962</b> Month Day Year	
5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>4-6-92</b> 9. AGE (In years last birthday) <b>69</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES VERON BEALL</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE BOLTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>MARY JANE BOLTON</b> Address <b>HOSPITAL RECORDS</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>450A</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last } DUE TO <b>Generalized advanced arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>-</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>-</b>	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. City or town) (County) (State) <b>-</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 1961</b> to <b>Jan 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 15 1962</b> and that death occurred at <b>9:45A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED <b>10/15/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-14-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		23d. LOCATION (City, town or county, (State) <b>Rockville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest B. Garton</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Harris</b>		25c. ADDRESS <b>-</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed in by the attending physician and completely filled in by the funeral director. DIRECTIONS: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u> c. LENGTH OF STAY IN 1b <u>Since 1948</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Allen Acres</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ashton</u> d. STREET ADDRESS <u>Allen Acres</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Grace</u> Middle <u>W.</u> Last <u>Manchester</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>26</u> Year <u>19 62</u>	
<b>5. SEX</b> <u>female</u>		<b>6. COLOR OR RACE</b> <u>white</u>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>August 5, 1874</u>	
<b>9. AGE</b> (In years last birthday) <u>87 yrs</u>		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>	
<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>New York</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Willis Leonard Wheeler</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Lillian Funk</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>	
<b>17. INFORMANT</b> <u>Mrs. A.I. Smith</u>		<b>Address</b> <u>Allen Acres Ashton, Maryland</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture abdominal aneurysm, aortic</u> DUE TO (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 hr</u> <u>20 yrs</u> <u>20 yrs</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 26</u> <u>1962</u> <b>to</b> <u>Jan 26</u> <u>1962</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 26</u> <u>1962</u> <b>and that death occurred at</b> <u>2:30 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>A.D. Bonifant</u> M.D.		<b>22b. DATE SIGNED</b> <u>Jan 31 '62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>A.D. Bonifant</u>		<b>22d. ADDRESS</b> <u>Severly Sping. Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>11-29-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>GREENWOOD CEMETERY</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>BROOKLYN New York</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WARNER E Pumphrey, Inc</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Kraus</u>	

REC'D BY REGISTRAR  
JAN 31 '62



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00864		00856	
1. PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>13 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>145 Silver Spring</u> d. STREET ADDRESS <u>14511 - Colosville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Mary Lay</u> First Middle Last 4. DATE OF DEATH <u>Jan. 30 1962</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/2/1917</u> 9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Staunton Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS. HERBERT L. Reynolds</u> Address <u>75 E. WAYNE AVE SILVER SPRING</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from <u>1/17/62</u> to <u>1/30/62</u> , that (H) (we) last saw the deceased alive on <u>1/30/62</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>H. C. Krugarsini</u> PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>1/31/62</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. ADDRESS <u>Richwell Med Center, Potomac</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-1-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Prince George Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. A. Zisk</u> Warner E. Pumphrey, Inc. Silver Spring, Md.		25a. REC'D BY REGISTRAR <u>EB 2 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Robert L. Pinaud</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be filled in by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00865

00857

(M)

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN b <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>McLean</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>4311 Woody Road</b> d. STREET ADDRESS <b>4311 Woody Road</b>	
3. NAME OF DECEASED (Type or print) <b>Ethel Waller Manship</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 9, 1887</b>	
9. AGE (In years, last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>14</b>	
11. IF UNDER 24 HRS. Hours <b>14</b> Mins. <b>00</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas G. Waller</b>		14. MOTHER'S MAIDEN NAME <b>Syriena O. Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>DAUGHTER: Mrs. Muriel E. Foote, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart Failure</b> (c) <b>Chr. Myelomonocytic Leukemia (leukemia)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <b>Interval between ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>22 January, 1962</b> to <b>24 January 1962</b> that (X) (we) last saw the deceased alive on <b>24 January, 1962</b> , and that death occurred <b>05:35 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>W. F. Warrender</b>		22b. DATE SIGNED <b>January 24, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. F. WARRENDER LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-25-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOSEPH GAWLERS FUNERAL HOME, WASH., D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 26 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			



TO HOSPITAL OR FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00866

Item 23b, Film G405 1/11/62 1wk

101858

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>417 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>1x</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>44 Bethesda</b> d. STREET ADDRESS <b>14522 Gretna St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ava</b> Middle <b>Mae</b> Last <b>Markman</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Causasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 16, 1915</b>
9. AGE (In years last birthday) <b>46</b> yrs		10. IF UNDER 1 YEAR Months <b>46</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Elmond Tart</b>	
14. MOTHER'S MAIDEN NAME <b>Norma Betts</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>Husband: Solomon Markman</b>		17. INFORMATION <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b> DUE TO <b>with widespread metastases</b> Conditions, if any, which gave rise to immediate cause (b) <b>approx 2 1/2 yrs</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>X</b> (this hospital) attended the deceased from <b>November 14, 1960</b> to <b>January 5, 1962</b> , that <b>X</b> (we) last saw the deceased alive on <b>January 5, 1962</b> , and that death occurred at <b>5:50PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>B Barclay Shepherd</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>B.M. SHEPPARD LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/9/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>		23d. LOCATION (City, town or county) (State) <b>ARLINGTON VIRGINIA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>P. J. Salomone</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
CHEVY CHASE FUNERAL HOME, CHEVY CHASE, MD.		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00867

859

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bel Pre Nursing &amp; Convalescent Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>District of Columbia</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>2800 Quebec Street N.W.</u>	
<b>3. NAME OF DECEASED</b> (Type or print, First Middle Last) <u>JULIE M. MAYER</u>		<b>4. DATE OF DEATH</b> (Type or print, Month Day Year) <u>January 6 1962</u>	
<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> (Type or print, Year last birthday) <u>February 17, 1877</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Pennsylvania</u>	
<b>13. FATHER'S NAME</b> <u>UNK</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Benkheimer</u>	
<b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u>		<b>17. INFORMANT</b> <u>Philip Goldstein, Atty. Woodward Bldg., D.C.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Complications of Old Age</u> (c) <u>Arterio-sclerotic cardiac-vascular disease</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>24 hrs.</u> <u>10 years</u> <u>10 years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that (I) (this hospital) attended the deceased from <u>7/26</u>, 19<u>60</u> to <u>1/6</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>11/6/62</u>, 19<u>62</u>, and that death occurred at <u>11 A.M.</u>, from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Samuel Diener</u>		<b>22b. DATE SIGNED</b> <u>1/6/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>SAMUEL DIENER</u>		<b>22d. ADDRESS</b> <u>4201 Mass. Ave., N.W., Washington, D.C.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Cremation</u>		<b>23b. DATE THEREOF</b> <u>Jan. 8, 1962</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Goldberg Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 8 '62</u>	
<b>ADDRESS</b> <u>4217 9th St. N.W., D.C.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Frank</u>	



CERTIFICATE OF DEATH

00868

00868

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN TB <b>4 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Vermont</b>		b. COUNTY <b>Huntington</b>		c. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <b>Wild Acres</b>		d. STREET ADDRESS <b>Wild Acres</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>U.S. Naval Hospital, Bethesda, Md.</b>		First <b>Aida</b>		Middle <b>MacLean</b>		Last <b>Mayo</b>		4. DATE OF DEATH Month <b>January</b>		Day <b>7</b>		Year <b>1962</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 7 1875</b>		9. AGE (In years last birthday) <b>86</b> yrs		if UNDER 1 YEAR Months <b>86</b>		Days <b>86</b>		if UNDER 24 HRS. Hours <b>86</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or land on country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles C. MacLean</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Manderson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Same as #2</b>		17. INFORMANT <b>Husband, Chester Mayo</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>Myocardial Infarction</b> DUE TO Conditions if any, which gave rise to immediate cause (b): <b>Coronary Artery Thrombosis</b> DUE TO (c): <b>Arteriosclerotic Heart Disease</b>		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c):		INTERVAL BETWEEN ONSET AND DEATH <b>4</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (X) (this hospital) attended the deceased from <b>4 January, 1962</b> to <b>7 January, 1962</b> , that (X) (we) last saw the deceased alive on <b>7 January, 1962</b> , and that death occurred <b>125AM</b> from the causes and on the date stated above.		22a. SIGNATURE <b>M. W. VOSS</b>		M.D. <b>M. W. VOSS LCDR MC USN</b>		ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE <b>1/11/62</b>		22c. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/11/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview</b>		23d. LOCATION (City, town or county) <b>Burlington, Vermont</b>		23e. REC'D BY REGISTRAR <b>Joseph F. BIRCH SONS Funeral Home</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		23g. DATE <b>JAN 9 '62</b>		23h. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00869									
CERTIFICATE OF DEATH									
Item 2 File G307 2/14/62 iwk 00861									
1. PLACE OF DEATH a. COUNTY		Montg							
MARYLAND									
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN TB							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		18							
3. NAME OF DECEASED (Type or print)		Rest Haven							
5 SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct 29-1873		38 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
U S Sect. & School Teacher		Monte, Co. Md.		L D A					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
William Monte		Virginia Purdom							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)									
422.2 DUE TO Arteriosclerotic Heart Disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO Chronic Myocarditis									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year									
Hour a.m. p.m. 19									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 1960, 19, to 1/19, 1962 that (I) (we) last saw the deceased alive on 1/19, 1962 and that death occurred at M, from the causes and on the date stated above									
22a. SIGNATURE									
Luciano L. Leal M.D.									
22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type)									
Luciano L. Leal M.D.									
22d. ADDRESS									
Gaithersburg, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE THEREOF									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City, town or county) (State)									
24. FUNERAL DIRECTOR'S SIGNATURE									
ADDRESS									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									
DATE									
JAN 23 1962									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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00870

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

100862

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>hant.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>16519 Old Farm Lane</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Helena Evangeline McGough</u>		4. DATE OF DEATH Month Day Year <u>Jan 19 1962</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 1, 1885</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. BIRTHPLACE (State or foreign country) <u>Melrose Mass.</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Alexander Muse</u>		14. MOTHER'S MAIDEN NAME <u>Anne <del>Muse</del> Jacquand</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Ferullo</u>		Address <u>6519 Old Farm Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1937</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>Sept 1961</u> to <u>Jan 1962</u> that (I) <u>was</u> last saw the deceased alive on <u>15 Jan 1962</u> and that death occurred at <u>1 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Herman C. Maganzini</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Herman C. Maganzini</u>		22d. ADDRESS <u>6519 Old Farm Lane, Rockville, Md</u>	
23a. BL R A. CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Stoneham, Massachusetts</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Jan 23 '62</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Living S. Thomas</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be signed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (14)  
15M 7 61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>2307 Rittenhouse St.</u>	
3. NAME OF DECEASED (Type or print) <u>Rosemary Helen McIntosh</u> First Middle Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH <u>1-4-1962</u> Month Day Year	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-31-25</u> Month Day Year
9. AGE (In years last birthday) <u>36</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>6</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>	
13. FATHER'S NAME <u>James E. Dawn Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lois Cecil</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-22-0960</u>	
17. INFORMANT <u>Wash. San &amp; Hosp. Records, T Pk. md.</u>		18. CRUISE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO <u>CARCINOMA OF LUNG</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO <u>CARCINOMA OF LUNG</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3-4 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Oct 20</u> , 19 <u>61</u> , to <u>1/4</u> , 19 <u>62</u> ; that (I) (we) last saw the deceased alive on <u>1/3</u> , 19 <u>62</u> , and that death occurred at <u>8:33</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>1/4/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>7105 - Rye Rd.</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/8/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>oakwood</u>		23d. LOCATION (City, town or county) (State) <u>Falls Church, Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Saffell Funeral Home</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>475 H ST. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>JAN 8 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Patient may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00872

Items 3 & 5 11-11-62 2/15/62 iwk

CERTIFICATE OF DEATH

00864

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San &amp; Hosp</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>11</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>adelphi</u> d. STREET ADDRESS <u>10525 Agemont Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>CHARLIE MAY MCLEAN</u>		<b>DATE OF DEATH</b> <u>Jan. 30 1962</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>12-3-88</u>
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>nsuf</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>W. Va. Charleston</u>
<b>13. FATHER'S NAME</b> <u>Charlie Blount</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ellen Estep</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>PT chart</u>	
<b>17. INFORMANT</b> <u>PT chart</u>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO <u>  </u> (e), stating the underlying cause last. (c) <u>  </u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 Hours</u> <u>8 Years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</b> <u>Rheumatic heart disease &amp; mitral stenosis</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)	
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)	<b>20f. City or town</b> (County) (State)
<b>21. I certify that (I) (the hospital) attended the deceased from</b> <u>1/5/6</u> <b>19</b> <u>  </u> <b>to</b> <u>1/30</u> <b>1962</b> ; that (I) (we) last saw the deceased alive on <u>1/30</u> <b>1962</b> , and that death occurred at <u>7:30 AM</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Hugh W. Ireay</u> <b>M.D.</b>		<b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	<b>22b. DATE SIGNED</b>
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>HUGH W. Ireay</u>		<b>22d. ADDRESS</b> <u>7105 - Riggs Road</u> <u>Lewisdale, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>Feb. 2/62</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Va</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Kalleys Funeral Home</u>		<b>25a. REC'D BY REGISTRAR</b> <u>Mr. Rainer</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hume</u>
<b>ADDRESS</b> <u>Inc.</u>		<b>DATE</b> <u>FEB 5 '62</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00873

00865

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>22 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Bethesda</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>4911 Hampdon Lane</b> d. STREET ADDRESS <b>4911 Hampdon Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Catherine</b> First <b>McNally</b> Middle <b>Virginia</b> Last <b>Embrey</b>		4. DATE OF DEATH <b>January 25</b> Month <b>19</b> Day <b>62</b> Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 22, 1889</b>	
9. AGE (In years last birthday) <b>72 yrs</b>		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE County & State, or foreign country <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lawrence Hines</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Embrey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Son: Lawrence Pugh, Same as #2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>420.0</b> DUE TO IMMEDIATE CAUSE (a) <b>Infarction of myocardium</b> Conditions, if any, which gave rise to immediate cause (b) <b>coronary artery occlusion</b> (a), stating the underlying cause last. DUE TO (c) <b>Atherosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Aortic stenosis</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 3, 1962</b> , to <b>Jan. 25, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 25, 1962</b> , and that death occurred <b>6:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>John W Brackett Jr</b> M.D. 22b. PHYSICIAN'S NAME (Type) <b>JOHN W. BRACKETT JR. LT MC USN</b>		22c. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-30-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> 24b. ADDRESS <b>Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and send them to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN b <b>9 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>					
3. NAME OF DECEASED (Type or print) <b>Hamilton</b>		First <b>Irvin</b>		Middle <b>Meadows</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		8. DATE OF BIRTH <b>17 December 1911</b>	
13. FATHER'S NAME <b>Irving Meadows</b>		14. MOTHER'S MAIDEN NAME <b>Edith Peyton</b>		9. AGE (In years last birthday) <b>50 years</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>yes 1939 to 1945</b>		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TRAUMATIC</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>7-2-1</b> <b>AORTIC INSUFFICIENCY</b>		17. INFORMANT <b>Wife Goldie Meadows</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
20f. (City or town) <b>Bethesda</b>		20g. (County) <b>Montgomery</b>		20h. (State) <b>Md.</b>	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 December, 1961</b> to <b>6 January, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 January, 1962</b> , and that death occurred at <b>217 PM</b> from the causes and on the date stated above					
22a. SIGNATURE <b>C. W. BRAMLETT</b>		22b. DATE SIGNED <b>1/8/62</b>		22c. PHYSICIAN'S NAME (Type) <b>C. W. BRAMLETT LCDR MC USN</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/8/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>East Lawn Memorial Garden</b>	
23d. LOCATION (City, town or county) <b>Harrisburg, Virginia</b>		23e. REC'D BY REGISTRAR <b>1962</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00867

1. PLACE OF DEATH a. COUNTY <b>Montgomery, Kensington MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton, Maryland</b>	
c. LENGTH OF STAY IN 1b <b>12/12/61 to 1/8/62</b>		d. STREET ADDRESS <b>11601 High View Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>MELCHER</b> Last <b>MELCHER</b>		4. DATE OF DEATH Month <b>January</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 2, 1869</b>
9. AGE (In years, months, days, hours, minutes) <b>92</b>		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Philip Melcher</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Rutter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>PAULINE C. HINCHMAN</b>		Address <b>SAME AS #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shock</b> <b>570</b> DUE TO <b>Mesenteric thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture (intracapsular) of left hip</b> DUE TO (c) <b>Fracture (intracapsular) of left hip</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1962</b> to <b>Jan 8, 1962</b> , that (I) (not) last saw the deceased alive on <b>Jan 7, 1962</b> , and that death occurred at <b>11:35 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Blaine H. Etg.</b>		22b. DATE SIGNED <b>Jan 8, 1962</b>	
22c. PHYSICIAN'S NAME (Type or print) <b>BLAINE H. ETG. M.D.</b>		22d. ADDRESS <b>8641 Colesville Rd Silver Spring, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-11-1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co.</b>		25a. REG'D BY REGISTRAR <b>DATE JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>W.W. Chambers Co.</b>		25c. REGISTRAR'S SIGNATURE <b>W.W. Chambers Co.</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00876

00868

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>2 1/2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u></u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Big Woods) Dickerson</u> d. STREET ADDRESS <u></u>	
3. NAME OF DECEASED (Type or print) <u>Rhoda N. Mercer</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 19 1893</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		9b. AGE (in years last birthday) <u>69 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Henry Orley</u>		14. MOTHER'S MARDEN NAME <u>Sarah Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>John I. Brown, Jr. #2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> DUE TO (b) <u>Arteriolonephrosclerosis</u> DUE TO (c) <u>DIABETES MELLITUS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from... <u>Jan 1</u> , 19 <u>62</u> , to <u>Jan 20</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on... <u>Jan 20</u> , 19 <u>62</u> , and that death occurred at... <u>3:30 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John I. Brown, Jr.</u>		22b. DATE SIGNED <u>1/21/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. C. Maganzini</u>		22d. ADDRESS <u>Rockwell End Rockville</u>	
23a. BURIAL, CREMATION, DATE THEREOF <u>Burial 1/24/62</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
23c. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Snowden</u>		25a. REC'D BY REGISTRAR <u>Jan 25 '62</u>	
ADDRESS <u>Rockwell End</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If page 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00877

CERTIFICATE OF DEATH

Item 1 Film G305 1/12/62 iwk

00869

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>	
c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		d. STREET ADDRESS <b>12128 Bluehill</b>	
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give address) <b>Suburban Hosp.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph A. Miller</b>	First Middle Last <b>Joseph A. Miller</b>	4. DATE OF DEATH <b>January 5 1962</b>	Month Day Year
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	8. DATE OF BIRTH <b>Nov-19-1960</b>	9. AGE (In years, if last birthday) <b>1</b> yrs. <b>11</b> days <b>16</b> hours <b>16</b> min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND -</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Joseph Andrew MILLER</b>	14. MOTHER'S MAIDEN NAME <b>MARY E McCauley</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Joseph A. Miller-Father-Same 2d</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>47X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Acute respiratory infection, influenza?</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>61</b> , to <b>Jan. 5</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>January 2, 1962</b> , and that death occurred at <b>4:30</b> M., from the causes and on the date stated above.			
22a. SIGNATURE <b>Belden R. Reap M.D.</b>		22b. DATE SIGNED <b>January 5, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		22d. ADDRESS <b>11502 GRANDVIEW AVE, SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF <b>Burial 1/8/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
		25b. REGISTRAR'S SIGNATURE <b>Will S. Hanes</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by a physician in 24 hours after death. It may be filled out by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00878

## CERTIFICATE OF DEATH

00870

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>20 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Saint Marys</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood</u> d. STREET ADDRESS <u>"Sotterley" Estate</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Edward (No middle name) Milton</u> f. First Middle Last g. SEX <u>Male</u> h. COLOR OR RACE <u>White</u> i. MARIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> j. DATE OF BIRTH <u>18 November 1908</u> k. AGE (In years IF UNDER 1 YEAR last birthday) <u>53</u> yrs. Months Days Hours Min l. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Curator</u> m. KIND OF BUSINESS OR INDUSTRY n. BIRTHPLACE (County & State, or origin country) <u>Massachusetts</u> o. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		<b>4. DATE OF DEATH</b> <u>January 16, 1962</u> p. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>World War II</u> q. SOCIAL SECURITY NO. <u>113-07-4207</u> r. INFORMANT <u>The Medical Record</u> s. ADDRESS <u>The Clinical Center, Bethesda 14, Maryland</u>	
<b>13. FATHER'S NAME</b> <u>Joseph John Newton</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>World War II</u> <b>16. SOCIAL SECURITY NO.</b> <u>113-07-4207</u> <b>17. INFORMANT</b> <u>The Medical Record</u> <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>205X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Mycosis fungoides</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <u>1 Week</u> <u>6 Years</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m. <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town, County) (State)</b> <b>21. I certify that</b> <u>He</u> (this hospital) attended the deceased from <u>December 27, 1961</u> to <u>January 16, 1962</u> that <u>he</u> (we) last saw the deceased alive on <u>January 16, 1962</u> , and that death occurred at <u>1:05 PM</u> from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>Frederick H. Welland, M.D.</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Frederick H. Welland, M.D.</u>		<b>22b. DATE SIGNED</b> <u>1-16-61</u> <b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>23b. DATE THEREOF</b> <u>1/17/62</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cedar Hill Crematory</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Suitland, Maryland</u>		<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph F. Birch's Sons</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 19 '62</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Hume</u>	

VR A15 (4)  
15M 9/60

*42 Hwy cock*





00879

## CERTIFICATE OF DEATH

Reg. Dist. No. 571

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>17 years</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>1709 Corwin Drive</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
f. STREET ADDRESS <b>1709 Corwin Drive</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ruth</b> Middle <b>MARY</b> Last <b>MISTER</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>28</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 5, 1899</b>
9. AGE (In years last birthday) <b>63</b> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13. BIRTHPLACE (State or foreign country) <b>Moherly, Missouri</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>William Sherman ORR</b>		16. MOTHER'S MAIDEN NAME <b>Lizzie Shaw</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>215-36-4482</b>	
19. INFORMANT <b>Daughter (Margaret)</b>		Address <b>Same as 2d.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(probable) overwhelming Infection</b> DUE TO <b>Subacute Aleukemic Leukemia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>6 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1956</b> to <b>27 JAN, 1962</b> , that I last saw the deceased alive on <b>27 JAN, 1962</b> , and that death occurred at <b>12:15 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick Barr</b>		ADDRESS (Street, city or town, state) <b>4500 College Ave.</b>	
PHYSICIAN'S NAME (Type) <b>F. Frederick BARR, M.D.</b>		DATE SIGNED <b>1-28-62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-31-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc.</b>		24a. REC'D BY REGISTRAR <b>31 '62</b>	
ADDRESS <b>Georgia Ave. Silver Spring, Md.</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 are in 305  
1-22-62  
FOR STATE HEALTH DEPT.

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00880 00872

**1. PLACE OF DEATH**  
a. COUNTY Montgomery **MARYLAND**  
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4514 Courtland Rd

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)  
a. STATE Ind b. COUNTY monty  
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda  
d. STREET ADDRESS 4514 Courtland Rd

**3. NAME OF DECEASED** (Type or print) Margaret M. CREAGER Moore  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**4. DATE OF DEATH** Jan 17 1962

**5. SEX** Female **6. COLOR OR RACE** White **7. MARRIED** ☒ NEVER MARRIED ☐ **8. DATE OF BIRTH** 5-27-1899 **9. AGE** (in years last birthday) 62 yrs. **IF UNDER 1 YEAR** Months 1 Days 17 **IF UNDER 24 HRS.** Hours 1 Min. 17

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) housewife **10b. KIND OF BUSINESS OR INDUSTRY** DR. **11. BIRTHPLACE** (State or foreign country) D.C. **12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME** Francis I. Creager **14. MOTHER'S MAIDEN NAME** Margaret Leary

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) ☐ **16. SOCIAL SECURITY NO.** 578-01-6295 **17. INFORMANT** J. N. Moore, Husband-same 2d Address 2d

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

**PART I. DEATH WAS CAUSED BY:**  
IMMEDIATE CAUSE (a) Aspiration of blood  
900.0 DUE TO  
Conditions, if any, which gave rise to immediate cause (b) Acute Alcoholism  
(a), stating the underlying cause last. } DUE TO (c)

**PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)**

**19. WAS AUTOPSY PERFORMED?** YES ☒ NO ☐

**20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.** **20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.) Found dead at foot of stair where she had fallen

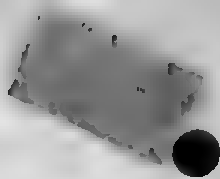
**20c. TIME OF INJURY** Month, Day, Year 1-17-62 **20d. INJURY OCCURRED** While at work ☐ Not While at work ☒ **20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) Home **20f. (City or town)** Bethesda **(County)** Monty **(State)** Ind

**21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from** Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

**ACTUAL SIGNATURE** Frank J. Blosschaw **CHIEF MEDICAL EXAMINER** ☐  
**EXAMINER'S NAME (Type)** FRANK J. Blosschaw **ASSISTANT MEDICAL EXAMINER** ☐  
**DEPUTY MEDICAL EXAMINER** ☒ **DATE SIGNED** 1-17-62  
Address (Street, city, town, or county) Washington, D. C.

**22a. BURIAL, CREMATION, REMOVAL (Specify)** Burial **22b. DATE THEREOF** 1/20/62 **22c. NAME OF CEMETERY OR CREMATORY** Mt. Olivet Cemetery **22d. LOCATION (City, town, or country, (State))** Washington, D. C.

**23. FUNERAL DIRECTOR** Robert A. Pumphrey, Bethesda, Maryland **24a. REC'D BY REGISTRAR** JAN 19 1962 **24b. REGISTRAR'S SIGNATURE** Arthur S. Hanna



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00873

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Fairway Hills</b> c. LENGTH OF STAY IN b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>6212 Vorlick Lane</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairway Hills</b> d. STREET ADDRESS <b>6212 Vorlick Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARCEL</b>	First <b>J.</b> Middle <b>MOREAU</b> Last <b>MOREAU</b>	4. DATE OF DEATH Month <b>Jan.</b> Day <b>31</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrical Engineer</b>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR <b>6</b> Months <b>5</b> Days IF UNDER 24 HRS. <b>6</b> Hours <b>5</b> Min.
11. BIRTHPLACE (State or foreign country) <b>Paris, France</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA-Nat.</b>	13. FATHER'S NAME <b>Alphonse Moreau</b>	14. MOTHER'S MAIDEN NAME <b>Eugenia Maitralain</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>577-09-3764</b>	17. INFORMANT <b>Wife</b> Address <b>Charlotte Moreau</b>	<b>Same as #2</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>(b)</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Found dead in bed.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>Jan. 31, 1962</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/3/62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '62</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00882

00874

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

### 1. PLACE OF DEATH

a. COUNTY

Montgomery

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Takoma Park

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Washington Sanatorium

### 3. NAME OF DECEASED

(Type or print)

M

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Merchant

### 13. FATHER'S NAME

Moses

I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)

No

### 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

Coronary occlusion

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Collapsed on floor at his office while at work

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Hour a.m.

Month, Day, Year

19

20d. INJURY OCCURRED

While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Frank J. Broschart

EXAMINER'S NAME (Type)

FRANK J. Broschart

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/28/62

22c. NAME OF CEMETERY OR CREMATORY

Nat'l. Mem. Park

22d. LOCATION (City, town, or country)

Falls Church, Va.

23. FUNERAL DIRECTOR

ADDRESS

Goldberg Funeral Home 4217 9th Street N.W.

### 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)

STATE

Maryland

b. COUNTY

Montgomery

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Silver Spring

d. STREET ADDRESS

512 Harding Dr.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH

Month

Day

Year

1

27

1962

8. DATE OF BIRTH

6-30-09

9. AGE (In years last birthday)

52 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

11. BIRTHPLACE (State as foreign country)

Penn.

12. CITIZEN OF WHAT COUNTRY?

USA

14. MOTHER'S MAIDEN NAME

Yetta

Address

Mrs Sylvia Morris

Wife

INTERVAL BETWEEN ONSET AND DEATH

sudden

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒

MEDICAL CERTIFICATION

24a. REC'D BY REGISTRAR

JAN 29 '62

24b. REGISTRAR'S SIGNATURE

Arthur L. Kraus





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN It <u>91 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>					2. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Lancaster</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pequea (Rural)</u> d. STREET ADDRESS <u>R.D. # 1</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kenneth Glenn Morrison</u>					4. DATE OF DEATH Month Day Year <u>January 25, 1962</u>				
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>26 July 1949</u> 9. AGE (in years last birthday) <u>12</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>Glenn R. Morrison</u> 14. MOTHER'S MAIDEN NAME <u>Florence Reinhart</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right Lower lobe pneumonia</u> 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Staphylococcal septicemia</u> (c) <u>Acute Lymphocytic leukemia</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Days</u> <u>2 Years</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>Pathologic fracture Right &amp; Left femoral neck, compression fractures L2 &amp; L3</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (a) (this hospital) attended the deceased from <u>October 26, 1961</u> to <u>January 25, 1962</u> , that (b) (we) last saw the deceased alive on <u>January 25, 1962</u> , and that death occurred at <u>12:10 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Frederick H. Welland</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Frederick H. Welland, M.D.</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>1-25-62</u> 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 29, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Colemanville Cem</u> 23d. LOCATION (City, town or county) (State) <u>Conestoga Twp. Penna</u>					24. FUNERAL DIRECTOR'S SIGNATURE <u>Peardon's Funeral Home</u> ADDRESS <u>Falls Church Va</u> 25a. REC'D BY REGISTRAR <u>JAN 29 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00884

00876

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodacres</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>6008 Cobalt Road</b>		d. STREET ADDRESS <b>6008 Cobalt Road</b>	
3. NAME OF DECEASED (Type or print) <b>Bert W Morrow</b>		4. DATE OF DEATH <b>Jan 26 19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/15/04</b>
9. AGE (In years last birthday) <b>57 yrs.</b>		IF UNDER 1 YEAR <b>4</b> Months <b>15</b> Days <b>15</b> Hours <b>62</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Office Dept.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iowa</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>A. M. Morrow</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Lindquist</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 2</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nella Morrow-Wife-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Adenocarcinoma of stomach with metastases to retroperitoneal glands</b> DUE TO (b) <b>one year</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Pernicious anemia</b> DUE TO (c) <b>one year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pernicious anemia</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>March 25, 1961</b> to <b>Jan 26, 1962</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1961</b> , to <b>Jan 26, 1962</b> that (I) <b>(1)</b> last saw the deceased alive on <b>Jan 26, 1962</b> , and that death occurred at <b>10A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Saul Hottzman</b> M.D.			
22b. DATE SIGNED <b>1/26/62</b>			
22c. PHYSICIAN'S NAME (Type) <b>Saul Hottzman</b>			
22d. ADDRESS <b>1800 Eye St. NW Wash DC</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>1/29/62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>			
23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>			
25a. REC'D BY REGISTRAR <b>FEB 1 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00885

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address, <u>3702 Randolph Road</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3702 Randolph Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>ALICE</u> First Middle Last <u>MUMME</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>January 7, 1962</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 13, 1901</u>					
<b>9. AGE</b> (In years last birthday) <u>60</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days		<b>11. IF UNDER 24 HRS</b> Hours Min.		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Sears Roebuck &amp; Co.</u>							
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kentucky</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>							
<b>13. FATHER'S NAME</b> <u>William Hampton</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Belle Blair</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				<b>16. SOCIAL SECURITY NO</b> <u>578-16-1247</u>							
<b>17. INFORMANT</b> <u>Wm. J. F. Mumme-Item# 2</u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> (b) <u>Carcinoma ovaries with generalized metastasis</u> (c) <u>175.0</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <u>6 hrs</u> <u>4 mon.</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURED</b> (Enter nature of injury in Part I or Part II of item 1b)							
<b>20c. TIME OF INJURY</b> Hour a.m. p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that (I) (this hospital) attended the deceased from Nov. 5, 1961, to Jan. 7, 1962, that (I) (we) last saw the deceased alive on Jan. 6, 1962, and that death occurred at 1:50 A.M. from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>P. P. Andrews</u>				<b>22b. ADDRESS</b> <u>4201 Fessenden St., N.W., Washington, D.C.</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>P.P. Andrews</u>				<b>22d. ADDRESS</b> <u>4201 Fessenden St., N.W., Washington, D.C.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>1/10/62</u>							
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn</u>				<b>23d. LOCATION (City, town or county)</b> <u>Rockville, Maryland</u> (State)							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler Funeral Home-1331 E. Montg. Ave. Rockville, Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>JAN 11 '62</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>C. W. J. Thomas</u>				<b>226. DATE SIGNED</b> <u>1-7-62</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be completed by the hospital or attending physician. Page 3 should be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

1-24  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00886  
CERTIFICATE OF DEATH  
00885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 16 <b>10 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hagerstown</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>Hamilton Blvd.</b> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Simon Jerome Murphy</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 27, 1890</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>19</b>	
11. IF UNDER 24 HRS Hours <b>19</b> Min. <b>62</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Lucy Palmer</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown. (If yes give war or dates of service))		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Agnes Balmond (Sister)</b>		Address <b>Hagerstown, Md.</b> <b>1032 Hamilton Blvd</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobular pneumonia, left lung, organism unidentified</b> 441X DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>unidentified</b> (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 28, 1961</b> , to <b>January 6, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 January 1962</b> , and that death occurred <b>0555AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>D. L. Kettering</b>		22b. DATE SIGNED <b>JAN 9 '62</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. L. KETTERING, LT MC USN</b>		22d. ADDRESS <b>US Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/10/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Catholic Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Jeanette, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S NAME <b>W. Warren Taltavull Funeral Home, 3603 14th St NW</b>		25. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00887

00887

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>185 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Waukegan</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>516 Oakwood Street</b> d. STREET ADDRESS <b>516 Oakwood Street</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>HELEN CHARLOTTE MURRAY</b>		<b>4. DATE OF DEATH</b> Month Day Year <b>January 12, 1962</b>	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>February 14, 1909</b>	
<b>9. AGE</b> (In years; If UNDER 1 YEAR, give birth date) <b>52</b> yrs. Months Days Hours M'n.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>		<b>11. BIRTHPLACE</b> County & State, or foreign country <b>Indiana</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>13. FATHER'S NAME</b> <b>William Bert Magness</b>	
<b>14. MOTHER'S MAIDEN NAME</b> <b>Nancy Brown</b>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>	
<b>16. SOCIAL SECURITY NO.</b> <b>Not available</b>		<b>17. INFORMANT</b> <b>The Medical Record</b>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Pulmonary Embolus, suspected</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Malignant Carcinoid with Metastases</b> DUE TO (c) <b>18 months</b>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I (this hospital) attended the deceased from July 11, 1961 to January 12, 1962 that (we) last saw the deceased alive on Jan. 12, 1962, and that death occurred at 6:35 AM from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <b>William B. Kremer</b> M.D.		<b>22b. DATE SIGNED</b> <b>January 12, 1962</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>William B. Kremer</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL, (Specify)</b> <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>1-13-1962</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Waukegan, Illinois</b>		<b>23d. LOCATION (City, town or county, State)</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Martin W. Hyung Co - 1300 N. St. N.W. WASH. D.C.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE JAN 15 '62</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 14 may be completed by the hospital or attending physician and completely filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00888  
00888

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>37 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>California</b> b. COUNTY <b>Lancaster</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>45051 Redwood Avenue</b> d. STREET ADDRESS <b>45051 Redwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bernice Ruth Muscardine</b>		4. DATE OF DEATH Month <b>January</b> Day <b>14</b> Year <b>19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 8, 1921</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Air Force</b>	
11. BIRTHPLACE (County & State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Aleck Griffin</b>		14. MOTHER'S MAIDEN NAME <b>Zura Ida Grogan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give word or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>466-22-1494</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO <b>Extensive pulmonary congestion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>leading to marked respiratory insufficiency.</b> DUE TO <b>Congenital heart disease with total anomalous pulmonary venous drainage and atrial septal defect,</b> (c) <b>(corrected); persistent left superior vena cava.</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>5 hours</b> <b>40 years</b>		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>(corrected); persistent left superior vena cava.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1</b>		20f. (City or town) (County) (State) <b>1</b>	
21. I certify that <b>1</b> (this hospital) attended the deceased from <b>December 8, 1961</b> to <b>January 14, 1962</b> that <b>1</b> (we) last saw the deceased alive on <b>January 14, 1962</b> , and that death occurred at <b>1:25 P.M.</b> on the causes and on the date stated above.		22a. SIGNATURE <b>R.P. Anderson</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>Richard P. Anderson</b>	
22b. DATE SIGNED <b>January 15, 1962</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1/16/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>--</b>		23d. LOCATION (City, town or county) (State) <b>Doport, Texas</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co. 2901 14th St., N.W. Washington 9, D.C.</b>		25a. REC'D BY REGISTRAR <b>1</b> 25b. REGISTRAR'S SIGNATURE <b>1</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>1 HR. 25 MIN.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b> d. STREET ADDRESS <b>MC KENDREE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HERBERT HOBBS MUSGROVE</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>31</b> Year <b>1962</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-92</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>STEPHEN WASHINGTON MUSGROVE</b>		14. MOTHER'S MAIDEN NAME <b>NELLIE LOUISE HOBBS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>214-28-0131</b>	
17. INFORMANT <b>HOSPITAL RECORD</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <b>CEREBRAL HEMORRHAGE</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 HOURS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 1950</b> to <b>JAN 31, 1962</b> that (I) last saw the deceased alive on <b>JAN 31, 1962</b> and that death occurred at <b>3:45 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles S. Whitaker, M.D.</b>		22b. DATE SIGNED <b>Feb 1, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>CHARLES S. WHITAKER, M.D.</b>		22d. ADDRESS <b>CLARKSVILLE, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Howard County, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>		25. REC'D BY REGISTRAR <b>FEB 5 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>		25c. DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be executed by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
00890															
00882															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Florida</b> b. COUNTY <b>St. Petersburg</b>											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>(Rural) Bethesda</b>				c. LENGTH OF STAY IN IB <b>3 days</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b>				d. STREET ADDRESS <b>2598, 46 Terrace N.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, NMMC</b>				First <b>Dallas</b>				Middle <b>Meredith</b>				Last <b>NEAL</b>			
3. NAME OF DECEASED (Type or print) <b>Dallas Meredith NEAL</b>				4. DATE OF DEATH <b>January 21 1962</b>				Month <b>January</b>				Day <b>21</b>			
5. SEX <b>Male</b>				6. COLOR OR RACE <b>Cauc</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH <b>2 November 1906</b>			
9. AGE (In years last birthday) <b>55</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Tennessee</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>John Thomas Neal</b>				14. MOTHER'S MAIDEN NAME <b>Ettie Mae Alexander</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>				16. SOCIAL SECURITY NO. <b>136-32-3354</b>			
17. INFORMANT <b>Wife-Mrs. Fyrn L. Neal</b>				Address <b>St. Petersburg, Fla., 2598, 46 Terrace N.</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous cell Carcinoma of the bronchus</b> DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> DUE TO (c) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 mos</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <b>10</b> (this hospital) attended the deceased from <b>18 January, 1962</b> , to <b>21 January, 1962</b> , that <b>1</b> (we) last saw the deceased alive on <b>21 January, 1962</b> , and that death occurred at <b>4:05 AM</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>P.G. Linaweaver, LCDR MC USN</b>				22b. DATE SIGNED <b>18 January 1962</b>				22c. PHYSICIAN'S NAME (Type) <b>P.G. Linaweaver, LCDR MC USN</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-23-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Memorial</b>				23d. LOCATION (City, town or county) (State) <b>St. Petersburg, Florida</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>				25a. REC'D BY REGISTRAR <b>JAN 24 '62</b>				25b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>			





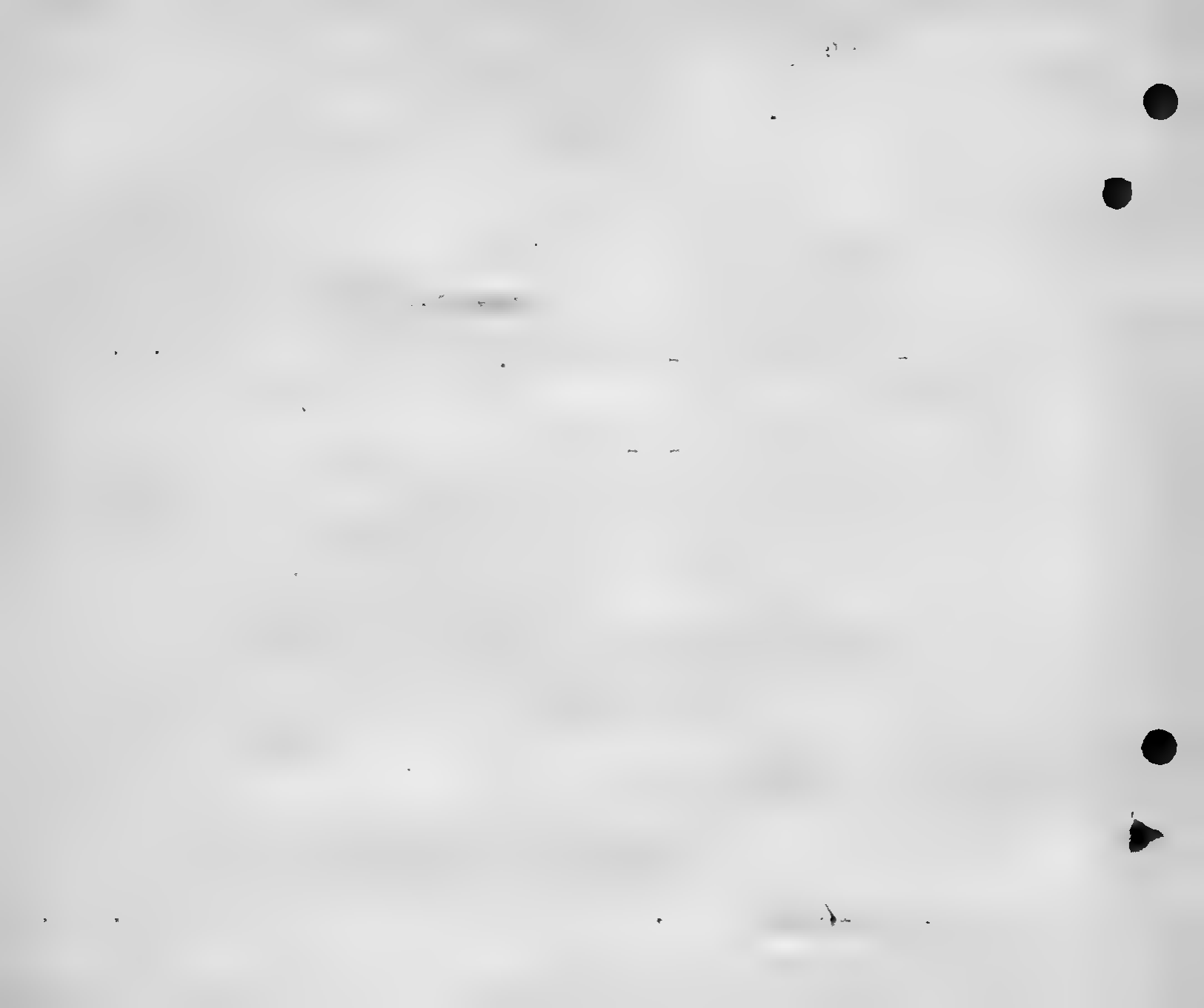
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY (in 1b) <u>2 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>4624 Leisnerin Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES B. NEHRING</u> First Middle Last 4. DATE OF DEATH <u>JAN 6 1962</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. AGE (in years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Board of Trade-Chicago, Ill.</u> 13. FATHER'S NAME <u>John Nehring</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wisconsin</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Wisconsin</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>321-03-1493</u>		17. INFORMANT <u>Minnie (unknown)</u> Address <u>4225 43rd St N.W.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Coronary Artery Heart Disease</u> (c) <u>Arteriosclerosis, Generalized</u> DUE TO <u>2 mos.</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Congestive Heart Failure, Arteriosclerotic Heart Dis</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Nov. 9, 1961</u> to <u>January 6, 1962</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>January 5, 1962</u> , and that death occurred at <u>9:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Belden R. Reap M.D.</u>		22b. DATE SIGNED <u>January 6, 1962</u>	
22c. PHYSICIAN'S NAME (Typed) <u>BELDEN R. REAP, M.D.</u>		22d. ADDRESS <u>Wheaton, Maryland</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Cremation 1/8/1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln crematory</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Harris Co 2901-14th St. N.W.</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>	

Wash. 9. D.C



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
00892  
CERTIFICATE OF DEATH

00884

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Silver Spring</b>			
c. LENGTH OF STAY IN 1b <b>4 mos.</b>				d. STREET ADDRESS <b>1915 Glen Ross Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanatorium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sallie F. Nelson</b>				4. DATE OF DEATH Month Day Year <b>Jan. 29 1962</b>			
5 SEX <b>F</b>		6 COLOR OR RACE <b>W</b>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 6, 1876</b>	
9 AGE (In years last birthday) <b>85 yrs</b>		IF UNDER 1 YEAR: Months <b>11</b> Days <b>22</b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS: Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Washington D. C.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>J. Phillip Fogarty</b>				14. MOTHER'S MAIDEN NAME <b>Johanna Cahill</b>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown; if yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO <b>None</b>			
17. INFORMANT <b>Mrs. Lewis Phelps-Sister-Chevy Chase, Md</b>				Address <b>3707 Shephard St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>120.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b></b> DUE TO <b></b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>Jan 29, 1962</b> , that (I) <b>no</b> last saw the deceased alive on <b>Jan 29, 1962</b> , and that death occurred at <b>4:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>J. Marion Bankhead</b> M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22b. ADDRESS <b>9241 Col. Blvd. Silver Spring, Md.</b> 22c. DATE <b>1/29/62</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/1/62</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b> 23d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b> ADDRESS <b>Bethesda, Maryland</b> 25a. REC'D BY REGISTRAR <b>1</b> 25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00893  
00885

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>21 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b> d. STREET ADDRESS <b>88 Hollingsworth Manor</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ralph</b> First <b>(None)</b> Middle <b>Newton</b> Last	4. DATE OF DEATH <b>January 16 1962</b> Month Day Year	5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 27, 1880</b> 9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentry</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Newton</b>		14. MOTHER'S MAIDEN NAME <b>(First name unknown) Clark</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unascertainable</b> 17. INFORMANT <b>The Medical Record</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral</b> 204.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <b>Acute Myelogenous leukemia</b> DUE TO (c) <b>Gastric ulcer</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>4 Weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 26, 1961</b> to <b>January 16, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 16, 1962</b> , and that death occurred at <b>9:30 AM</b> on the causes and on the date stated above.			
22a. SIGNATURE <b>Frederick H. Welland, M.D.</b>		22b. DATE SIGNED <b>1-16-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frederick H. Welland, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/19/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>West Laurel Hill Cemetery, Philadelphia, Pa.</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton, Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 31 '62</b> DATE 25b. REGISTRAR'S SIGNATURE <b>Clifford S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
IIM 9

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00894  
00888  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>3 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Douglas</u> Last <u>Nuse Jr.</u>		d. STREET ADDRESS <u>324 Cedar Lane</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>1/31/62</u>		9. AGE (in years last birthday) <u>3</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Douglas Nuse, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lois Pace</u>	
15. WAS DECEASED EVER U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <u>Father</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hrs</u> <u>2 1/2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>21 Jan 62</u> to <u>10 15 PM</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>10 PM 31 Jan 62</u> and that death occurred at <u>10 M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Francis J Truendle</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS J TRUENDLE</u>		22d. ADDRESS <u>809 Viers Mill Rd, Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Park Heights</u>		23d. LOCATION (City, town or county) (State) <u>Brunswick mcs</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Felix Funeral Home Brunswick md</u>		25a. REC'D BY REGISTRAR <u>FEB 6 62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00895  
CERTIFICATE OF DEATH

00887

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN (b) <b>Since 2-12-61</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Carroll Hall Sanitarium</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington #2</b> d. STREET ADDRESS <b>3906 Washington St.</b> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Josephine</b> Middle <b>A.</b> Last <b>Parce</b>		4. DATE OF DEATH Month <b>JAN.</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 25-1876</b> 9. AGE (In years last birthday) <b>85</b> yrs. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> IF UNDER 24 HRS.: Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bolder, Colorado</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Charles B. Andersen</b>		14. MOTHER'S MAIDEN NAME <b>Catharine Norberg</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>John R. Parce</b>		Address <b>3906 Washington st. Kensington, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Abdominal Aortic Aneurysm</b> Conditions, if any, which gave rise to immediate cause (b) <b>Generalized Atherosclerosis</b> (a), stating the underlying cause last. } DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>12</b> p.m. <b>12</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Feb 12, 1961</b> 20f. (City or town) <b>Jan 5, 1962</b> (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 12, 1961</b> to <b>Jan 5, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 4, 1962</b> and that death occurred at <b>1:37 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe MD</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe, MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22d. ADDRESS <b>10,511 Summit Ave., Kensington, Md.</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-8-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION (City, town or county) (State) <b>Prince George County Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey Inc.</b>		25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>C. E. H. H. H.</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00896

00888

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Darnestown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9110 Darnestown Road</b>		d. STREET ADDRESS <b>9110 Darnestown Road</b>	
3. NAME OF DECEASED (Type or print) <b>Harold McElwan Pease</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/94</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carpentering</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Arthur Pease</b>		14. MOTHER'S MAIDEN NAME <b>Lura McElwan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Ruby T. Pease-Wife-same 2d</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for a), b), and c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE CORONARY THROMBOSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } b) <b>CHRONIC CORONARY INSUFFICIENCY</b> c) <b>ARTERIO SCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
INTERVAL BETWEEN ONSET AND DEATH <b>30 MINUTE</b> <b>20 YEARS</b> <b>20 YEARS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County, (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>APRIL 10, 1960</b> to <b>JAN 7, 1962</b> that (I) last saw the deceased alive on <b>DEC 15, 1961</b> , and that death occurred at <b>10 A</b> M, from the causes and on the date stated above			
22a. SIGNATURE <b>Gordon S. Rosenberger</b>		22b. DATE SIGNED <b>Jan 7, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gordon S. Rosenberger, M.D.</b>		22d. ADDRESS <b>310 W. Montgomery Ave, Rockville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1/10/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION City, town or county, (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00897

00889

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>23 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Atlantic City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>67X-3</b> d. STREET ADDRESS <b>534 Spring Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Coletta Denise Peeler</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1962</b>		5. SEX <b>Female</b>	
6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 19, 1961</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		9. AGE (in years last birthday) Years <b>7</b> Months <b>11</b> Days <b>21</b> Hours <b></b> Min. <b></b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Dodson Louie Peeler</b>	
14. MOTHER'S MAIDEN NAME <b>Mildred Louise Tharpe</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiac arrest, operative</b> DUE TO (b) <b>Congenital Heart Disease - Ventricular Septal Defect &amp; Patent Ductus Arteriosus</b> DUE TO (c) <b></b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 am. v.</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour <b>a.m.</b> Month, Day, Year <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>		20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that (X) this hospital attended the deceased from <b>December 17, 1961</b> to <b>January 9, 1962</b> that (X) (we) last saw the deceased alive on <b>January 9, 1962</b> , and that death occurred at <b>10:40 AM</b> on the causes and on the date stated above					
22a. SIGNATURE <b>Richard P. Anderson</b>		22b. DATE SIGNED <b>1-9-62</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard P. Anderson, M.D.</b>	
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		22e. REC'D BY REGISTRAR <b></b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Jan. 11, 1962</b>		23b. DATE THEREOF <b></b>		23c. NAME OF CEMETERY OR CREMATORY <b>Travers Funeral Home, Inc. 384-K. D. Ave.</b>	
23d. LOCATION (City, town or county) <b>Atlantic City, N.J.</b>		23e. (State) <b></b>		23f. (Country) <b></b>	

9 VVVVVVV E V



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00898

00890

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>13 days 13 1/2 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8906 Kines Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> First <u>ELIZABETH</u> Middle <u>NMN</u> Last <u>PFEUFER</u>		4. DATE OF DEATH <u>JANUARY 8 1962</u> Month <u>JANUARY</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>JANUARY 23, 1950</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital Record.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Phillip Dinkel</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Stephan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>100-1-100000</u>	
17. INFORMANT <u>Hospital Record.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Myocardial failure</u> (b) DUE TO <u>myocardial fibrosis + uremia</u> (c) DUE TO <u>cholelithiasis + acute cholecystitis + cholangitis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes months to weeks years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6-13-1961</u> to <u>1-8-1962</u> that (I) (we) last saw the deceased alive on <u>1-8-1962</u> , and that death occurred at <u>3 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. Shultz, M.D.</u> M.D.		22b. DATE SIGNED <u>1-8-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles R. Shultz, M.D.</u>		22d. ADDRESS <u>6 Tanager Lane, Simpsonville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>JAN. 11, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Blondale Queens to New York</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W., Wash., D.C.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00899 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00899

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN (b) <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. SANITARIUM &amp; HOSPITAL</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>8439 12th AVENUE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Genevieve Claire Plummer</u>		<b>4. DATE OF DEATH</b> Year <u>1962</u> Month <u>10</u> Day <u>1</u>	
<b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>WHITE</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MAR. <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 18 1882</u> <b>9. AGE</b> (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min <u>0</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>DEERRY PENN.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>AMERICAN</u>		<b>13. FATHER'S NAME</b> <u>THEODORE WINGARD</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> <b>16. SOCIAL SECURITY NO.</b> <u>?</u> <b>17. INFORMANT</b> <u>HARVEY HAUN</u> Address <u>8439 12th AVE SILVER SPRING</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 22a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>0</u> p.m. <u>0</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-11-62</u> Address (Street, city, town, or county) (State)			
<b>SIGNATURE</b> <u>Frank J. Broschanski</u> <b>EXAMINER'S NAME</b> (Type) <u>Frank J. Broschanski</u> <b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Removal</u> <b>22b. DATE THEREOF</b> <u>1/12/1962</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Coles Cemetery</u> <b>22d. LOCATION</b> (City, town, or country) (State) <u>Derry, Pennsylvania</u> <b>23. FUNERAL DIRECTOR</b> <u>The S. H. Hines Co.</u> <b>24a. REC'D BY REGISTRAR</b> <u>2901-14th St N.W. Washington D.C.</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Hines</u> <b>DATE</b> <u>JAN 15 '62</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00900

00892

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if out of corporate limits write RURAL and give nearest town) <u>17220 Colesville Road</u> c. LENGTH OF STAY IN 1b <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Belmont Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7723 Carroll Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>VIRGINIA ROBERTA PRALLE</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>13</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>April 15, 1884</u>	
<b>9. AGE</b> (In years) <u>77</u> yrs. <u>13</u> Months <u>62</u> Days <u>19</u> Hours <u>62</u> Min.		<b>10. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D. C.</u>	
<b>11. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Robert Clarvoe</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Jennie Lomb</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>G. Albert Pralle 7723 Carroll Ave. Tak. Pk. Md.</u>	
<b>17. INFORMANT</b> <u>Address</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>2 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c) <u>many years</u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18.)		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u>	
<b>20d. INJURY OCCURRED</b> <u>While at work</u> <input type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> <u>Washington, D. C.</u>		<b>20g. (County)</b> <u>Montgomery</u>	
<b>20h. (State)</b> <u>Md.</u>		<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>1/11</u> to <u>1/13</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/12</u> , 19 <u>62</u> and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.	
<b>22a. SIGNATURE</b> <u>John P. Martin MD</u>		<b>22b. DATE</b> <u>1/13/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN P. MARTIN, MD</u>		<b>22d. ADDRESS</b> <u>Medical Center, Sandy Spring</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/15/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rock Creek Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Washington, D. C.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur Walters</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 17 '62</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. King</u>		<b>25c. ADDRESS</b> <u>254 Carroll St, N.W. Wash, D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00901  
CERTIFICATE OF DEATH

00893

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>6 mo.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>LeDeau Gardens Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>3600 Conn. Ave., N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Morgan Purdon</b>		4. DATE OF DEATH <b>January 20 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DATE OF BIRTH <b>Oct 19, 1883</b>		8. AGE (In years last birthday) <b>78</b> yrs. <b>78</b> Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian-Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nebraska</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Nebraska</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George H. Morgan</b>		14. MOTHER'S MAIDEN NAME <b>Mary Brownson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-07-4797</b>	
17. INFORMANT <b>Mrs Frederick Gutheim, Dickerson, Maryland</b>		Address <b>Dickerson, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Embolism</b> DUE TO (c) <b>Pneumonia, Bronchial</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Stat</b> <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED <b>19</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>19</b>		20f. (City or town) <b>19</b> (County) <b>19</b> (State) <b>19</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>Sep 1961</b> to <b>Jan 20 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 19 1962</b> , and that death occurred at <b>12:45</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Robert T. Thibadeau</b>		22b. DATE SIGNED <b>Jan 20, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert T. Thibadeau, M.D.</b>		22d. ADDRESS <b>10609 Concord St., Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1/20/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City, town or county) <b>Prince George Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lyson Wheeler</b>		24b. ADDRESS <b>Funeral Home-1331 E. Montg. Ave. Rockville, Md.</b>	
25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>		25b. REGISTRAR'S SIGNATURE <b>W. L. Tinsley</b>	



TO HOSPITAL OR AN ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 7-61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00902  
00894  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b> c. LENGTH OF STAY IN b <b>76 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington, D. C.</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b> d. STREET ADDRESS <b>5913 Essex Court, SE</b>	
3. NAME OF DECEASED (Type or print) <b>George Thomas Rael</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 62</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 October 1946</b>
9. AGE (In years last birthday) <b>15</b> yrs.		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>	11. IF UNDER 24 HRS. Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>no</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mr. George J. Rael</b>		14. MOTHER'S MAIDEN NAME <b>Ruth T. Picton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>no</b>	
17. INFORMANT <b>mother-Mrs. Ruth T. Clayton Same as #2</b>		Address <b>Washington, D. C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute Lymphocytic Leukemia</b> 2.04.3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>14 Nov. 1961</b> to <b>26 Jan. 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>26 Jan. 1962</b> end that death occurred at <b>9:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>D. L. Kettering, LT MC USN</b>		22b. DATE SIGNED <b>1-26-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. L. Kettering, LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-29-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Suitland</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Simmons Funeral Home, Good Hope Rd., Anacostia</b>		25a. REC'D BY REGISTRAR <b>DOAN 3 0 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 and place them in the envelope provided. The envelope should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00903

Item 21 Film GS-5 1/9/62 ink

00895

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN b. <u>6 days</u>	
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
3. NAME OF DECEASED (Type or print) <u>Jo Anne Reid</u>		4. DATE OF DEATH <u>January 1, 1962</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
6. SEX <u>Female</u>		7. CO. OR RACE <u>White</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <u>March 29, 1959</u>		10. AGE (In years last birthday) <u>2</u> yrs.		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James R. Reid</u>		14. MOTHER'S MAIDEN NAME <u>Louise Pinney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Cystic fibrosis of pancreas</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2-4 Weeks</u> <u>2 1/2 Years</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>December 26, 1961</u> to <u>January 1, 1962</u> , that (I) (we) last saw the deceased alive on <u>January 1, 1962</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>William T. Butler MD</u>		22b. PHYSICIAN'S NAME (Type) <u>William T. Butler, M.D.</u>		22c. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>	
22d. (City, town or county)		22e. (State)		22f. DATE <u>1-1-62</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 4, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
23d. LOCATION (City, town or county) <u>Frederick</u>		23e. (State) <u>Maryland</u>		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son</u>		24a. ADDRESS <u>Frederick, Maryland</u>		24b. DATE <u>JAN 4 1962</u>	
24c. (City, town or county)		24d. (State)		24e. (Country)	

VR A15 (4)  
15M 9/



CERTIFICATE OF DEATH

Reg. Dist. No. 14899

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONT.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUMNER</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SUMNER</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5116 SCARSDALE RD.</b>		d. STREET ADDRESS <b>5116 SCARSDALE RD.</b>	
3. NAME OF DECEASED (Type or print) <b>MRS ANNIE B REYNOLDS</b>		4. DATE OF DEATH <b>Jan. 26 1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14 1882</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dr. V. V. Kaman Munnithayson</b>		14. MOTHER'S MAIDEN NAME <b>Annie Farnendis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Edwin Wood, Sumner Md.</b>		Address <b>5116 Scarsdale Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Acute coronary insufficiency</b> DUE TO (b) <b>Acute coronary occlusion</b> DUE TO (c) <b>coronary Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>5 minutes</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-22</b> , 1962, to <b>1-26</b> , 1962, that I last saw the deceased alive on <b>1-24</b> , 1962, and that death occurred at <b>6:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell M. Tilly, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>4701 Mass. Ave. N.W., Wash. D.C.</b>	
PHYSICIAN'S NAME (Type) <b>Russell M. Tilly Jr</b>		DATE <b>1-26-62</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-62</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Cherry Chase Funeral Home</b>		ADDRESS <b>5103 Wise Ave N.W.</b>	
24a. REC'D BY REGISTRAR <b>JAN 29 1962</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be filed by the hospital or attending physician.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
00905														
00897														
1. PLACE OF DEATH COUNTY <u>Montgomery</u> M					2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Levittown</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Levittown</u> d. STREET ADDRESS <u>30 Picwick Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U. S. Naval Hospital, Bethesda, Md.</u>														
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lisa</u> <u>Machelle</u> <u>Rice</u>					4. DATE OF DEATH Month Day Year <u>January</u> <u>27</u> <u>19 62</u>									
5. SEX <u>Female</u>					6. COLOR OR RACE <u>Cauc</u>					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>					10b. KIND OF BUSINESS OR INDUSTRY					B. DATE OF BIRTH <u>19 October 1961</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>					9. AGE (In years last birthday) <u>3</u> <u>10</u> yrs.					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Robert D. Rice</u>					14. MOTHER'S MAIDEN NAME <u>Betty J. Parks</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Hospital Records</u> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.5</u> DUE TO <u>Congenital Heart Disease</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) DUE TO <u>3 mos.</u>										INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)				
21. I certify that (If (this hospital) attended the deceased from <u>8 Jan</u> <u>19 62</u> to <u>27 Jan</u> <u>19 62</u> that (X) (we) last saw the deceased alive on <u>27 Jan</u> <u>19 62</u> , and that death occurred at <u>1:45 AM</u> on the causes and on the date stated above.										22b. DATE SIGNED				
22a. SIGNATURE <u>B. W. SHEPARD</u> <u>LT MC USN</u> M.D.										22c. PHYSICIAN'S NAME (Type) <u>U.S. Naval Hospital, Bethesda Md.</u>				
22d. ADDRESS <u>U.S. Naval Hospital, Bethesda Md.</u>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										23b. DATE THEREOF <u>1-30-62</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Alto Rest Cemetery</u>										23d. LOCATION (City, town or county) (State) <u>Altoona, Pennsylvania</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler</u> <u>Rockville, Maryland</u>										25a. REC'D BY REGISTRAR <u>JAN 30 '62</u>				
25b. REGISTRAR'S SIGNATURE <u>Tyson Wheeler</u>														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN TB <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4913 Chevy Chase Blvd.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>55 Chevy Chase</b> d. STREET ADDRESS <b>4913 Chevy Chase Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARY FISKE ROBBINS</b> First Middle Last 4. DATE OF DEATH <b>1 15 1962</b> Month Day Year		5. SEX <b>female</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1/12/81</b> 9. AGE (In years last birthday) <b>81</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fredrick William Fiske</b>		14. MOTHER'S MAIDEN NAME <b>Isabella Tiffany Hartwell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b> 17. INFORMANT <b>Mary Louise Robbins</b> Address <b>same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary Failure (several years)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Recent 5 weeks</b> DUE TO (b) <b>Cerebral thromboses</b> DUE TO (c) <b>Pneumonia + Congestive HF Failure 5 wks ago</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased <b>about 1945</b> to <b>15 Jan., 1962</b> that (I) <b>(yes)</b> last saw the deceased alive on <b>13 Jan., 1962</b> and that death occurred <b>5:30</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard B. Castell</b> M.D.		22b. DATE SIGNED <b>15 Jan 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard B. Castell</b>		22d. ADDRESS <b>Mayflower Hotel</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>1/16/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		25. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be filed by the hospital or attending physician. Page 2 may be filed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4) C  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00907

111899

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>23 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>1925 Biltmore St. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fredarich</u> Middle <u>Augustus</u> Last <u>Rodgers</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-92</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>9</u>	11. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Sheet Metal Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u>	
11. BIRTHPLACE County & State or foreign country <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Rodgers</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Coyne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Wash. San. &amp; Hosp. Records</u>	
17. INFORMANT <u>Wash. San. &amp; Hosp. Records</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate &amp; Extensive Generalized Bone metastasis</u> Conditions, if any, which gave rise to immediate cause (b) <u>177X</u> (c) <u>Terminal Left Parotitis &amp; Bronchopneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>8 yrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> P.M.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Stay 8</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 8</u> , 19 <u>62</u> to <u>Jan 23</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> , 19 <u>62</u> and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth F. Laughlin</u> M.D.		22b. DATE SIGNED <u>1-23-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Kenneth F. Laughlin</u>		22d. ADDRESS <u>934 Ellsworth St. Beltsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1/27/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>JAN 26 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. H. Hines</u>		25c. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00908

CERTIFICATE OF DEATH

Item 12 Film G305 1/13/62 mh

00908

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. NAVAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>93X-3</u> d. STREET ADDRESS <u>955 So. Columbus Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES MARGARET ROHRER</u>		4. DATE OF DEATH Month Day Year <u>JAN 13 1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>CAU</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-14-61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>JAPAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PAUL W. ROHRER</u>		14. MOTHER'S MAIDEN NAME <u>SARAH T. TALIAFERRO</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>PAUL W. ROHRER 955 S. COLUMBUS ST. ARLINGTON, VA.</u>	
17. INFORMANT <u>PAUL W. ROHRER 955 S. COLUMBUS ST. ARLINGTON, VA.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO <u>754.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>CONGENITAL Heart Disease</u> (b) <u>7mos</u> (c) <u>MONGOLOID (DOWN'S Syndrome)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JAN 11</u> , 19 <u>62</u> to <u>JAN 13</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>JAN 12</u> , 19 <u>62</u> , and that death occurred at <u>0939</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frederic Alan Schulaner</u>			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>FREDERIC ALAN SCHULANER LT MC USN U. S. NAVAL HOSPITAL, BETHESDA, MD.</u>			
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>11/15/1962</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Graham Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Orange Virginia</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>For Fitzgerald Funeral Home Arlington, Va</u>			
25a. REC'D BY REGISTRAR <u>DATE JAN 16 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be completed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00909  
00901

Item #8-film 6205 - 1/24/62-mm

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>12 hr. 55 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. Alban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Res. date before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1726 - Wilmarl. St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel M. Schafer</u> First Middle Last 4. DATE OF DEATH <u>Jan 17 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>8/17/1894</u> 9. AGE (In years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Clerical</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Richard Evans</u> 14. MOTHER'S MAIDEN NAME <u>Leola Boswell</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>John Schafer</u> Address <u>1726 Wilmarl. St.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED <u>at work</u> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from: <u>10-25-1961</u> to <u>1-17-1962</u> ; that (I) <u>(the)</u> last saw the deceased alive on <u>1-17-1962</u> , and that death occurred at <u>10:30</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Edward Lewis, Jr., M.D.</u> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>EDWARD LEWIS, JR.</u> 22d. ADDRESS <u>5800 Beech Ave., Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-22-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u> 23d. LOCATION (City, town or county) (State) <u>Arlington Va., Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Deaf Funeral Home</u> ADDRESS <u>4812 Deane Rd</u> 25a. REC'D BY REGISTRAR <u>John S. Kraus</u> DATE <u>JAN 22 '62</u> 25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7, 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00910  
CERTIFICATE OF DEATH

00902

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> c. LENGTH OF STAY IN 1b <b>6 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium + Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if last tuition; Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>41X3</b> d. STREET ADDRESS <b>1431 Somerset Place</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daniel H.M.N. Schechter</b>		4. DATE OF DEATH Month Day Year <b>January 11 1962</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 10, 1884</b> 78 yrs.
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>78</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Roumania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac Schechter</b>		14. MOTHER'S MAIDEN NAME <b>Minnie (unknown to patient)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Washington Sanitarium and Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Pulmonary Fibrosis.</b> (c) <b>525X</b> DUE TO (e), stating the underlying cause last PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>Pneumonia - Emphysema - Arteriosclerotic Heart Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>7 days</b> <b>10 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) <b>Washington</b>	
20e. (County)		20f. (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19 <b>57</b> to....., 19 <b>62</b> , that (I) (we) last saw the deceased alive on....., 19 <b>62</b> , and that death occurred at....., from the causes and on the date stated above.			
22a. SIGNATURE <b>Benjamin Sackon</b> M.D.		22b. DATE <b>1/11/62</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>7733 Alaska Ave N.W. Washington D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/12/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT. ZION CEM.</b>		23d. LOCATION (City, town or county) <b>MASPEETH L.D. N.Y.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Waldorf Home</b>		25a. REC'D BY REGISTRAR <b>12 62</b>	
ADDRESS <b>4217-9th St N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>1 1/2 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b> d. STREET ADDRESS <b>508 New York Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sarah</b> First Middle Last 4. DATE OF DEATH <b>Jan. 22 1962</b> Month Day Year		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>? 1882</b> 9. AGE (In years last birthday) <b>79</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>Lithuania</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Mendel Schaeffer</b> 14. MOTHER'S MAIDEN NAME <b>Kale ?</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> 16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT (daughter) <b>Florence S Steinberg</b> Address <b>904 Highland Dr. Silver Spring, Md.</b>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Acute myocardial infarction</b> 420.0 DUE TO <b>Anterior wall M.I.</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour e.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Jan 20 1962</b> to <b>Jan 22 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 22 1962</b> and that death occurred at <b>10A</b> M. from the causes and on the date stated above. 22a. SIGNATURE <b>Herman C. Maganzini, M.D.</b> 22b. DATE SIGNED <b>1/22/62</b> 22c. PHYSICIAN'S NAME (Type) <b>Herman C. Maganzini, M.D.</b> 22d. ADDRESS <b>Rockville Medical Center</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Jan 24, 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Mem. Park</b> 23d. LOCATION (City, town or county) (State) <b>Falls Church, Va.</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kimes</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

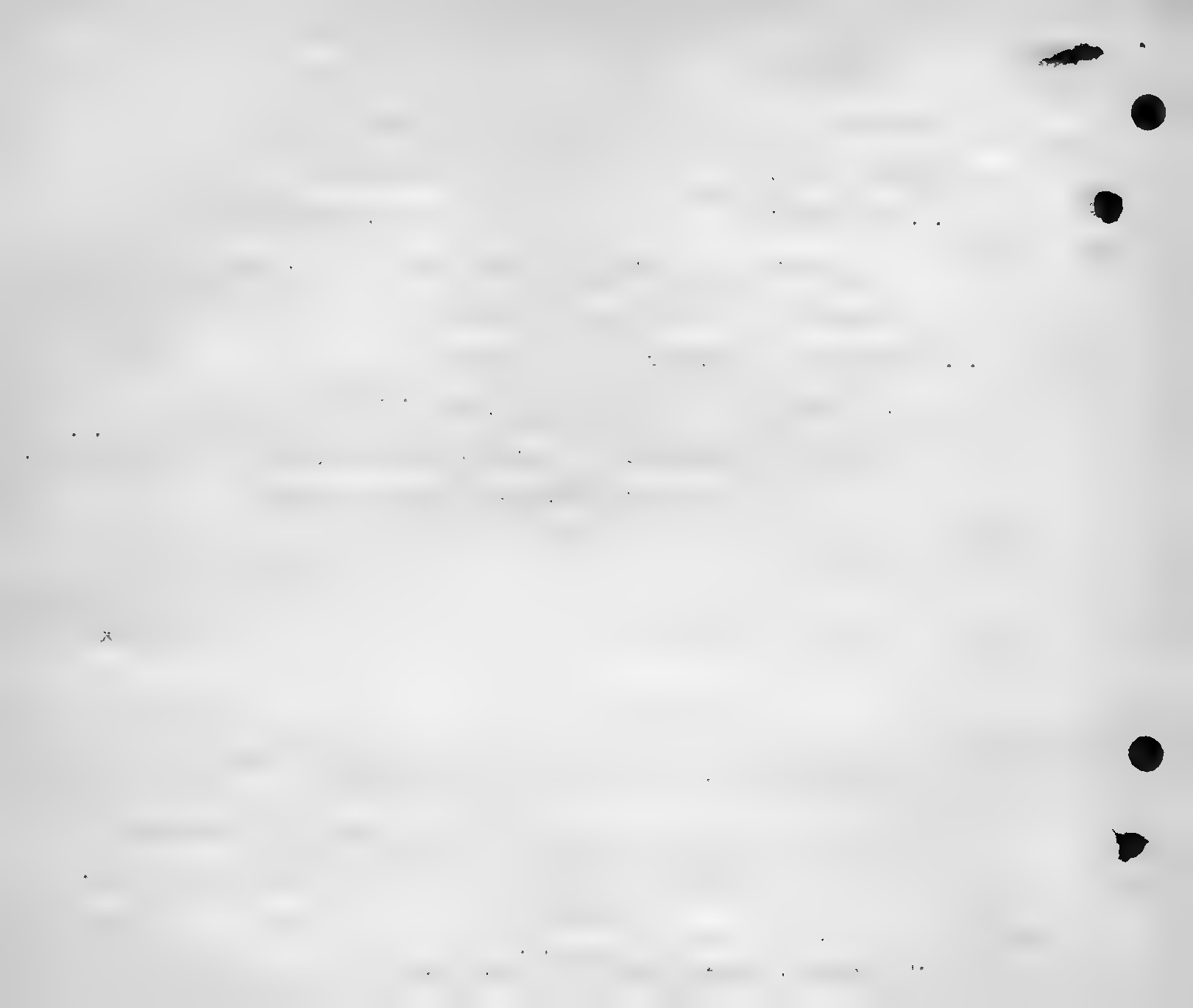
## CERTIFICATE OF DEATH

00912

00901

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <u>Montgomery</u> <b>MARYLAND</b> <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u> <b>c. LENGTH OF STAY in</b> <u>52 days</u> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <u>U.S. Naval Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <b>a. STATE</b> <u>Kansas</u> <b>b. COUNTY</b> _____ <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Wichita</u> <b>d. STREET ADDRESS</b> <u>115 S. Rutan Street</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Andrew</u> <u>Frank</u> <u>Schoeppel</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>January</u> <u>21</u> <u>1962</u> Month Day Year	
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>Caucasian</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>23 November 1894</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years IF UNDER 1 YEAR IF UNDER 24 HRS.) <u>67</u> yrs. last birthday, Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>U.S. Government</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Senator</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Kansas</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George J. Schoeppel</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Philip</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give year or dates of service) <u>yes</u> <u>WWI</u>		<b>16. SOCIAL SECURITY NO.</b> <u>120-22-55x</u> <b>17. INFORMANT</b> <u>Marie T. Schoeppel (Wife)</u> <b>Address</b> <u>Washington, D.C.</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Pulmonary embolism, bilateral, multiple</u> 465X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last DUE TO (c) _____		<b>INTERVAL BETWEEN ONSET AND DEATH</b> _____	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a,</b> _____			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ <b>(County)</b> _____ <b>(State)</b> _____	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1 December...</u> <u>1961</u> , to <u>21 January, 1962</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>21 January...</u> <u>1962</u> , and that death occurred at <u>1255 PM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>[Signature]</u>		<b>22b. DATE SIGNED</b> <u>21 January 1962</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type or print) <u>M. C. WILBER CDR MC USN</u>		<b>22d. ADDRESS</b> <u>U.S. Naval Hospital, Bethesda, Md.</u>	
<b>23a. BURIAL, CREMATION REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-25-62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Old Mission Cemetery</u>		<b>23d. LOCATION</b> (City, town or country) <u>Wichita</u> <u>Kansas</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>[Signature]</u> <b>ADDRESS</b> <u>Washington, D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 24 '62</u>	
<u>Gawler's Sons Inc., Funeral Home 1756 Penn. Ave.</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event, within 72 hours after death.



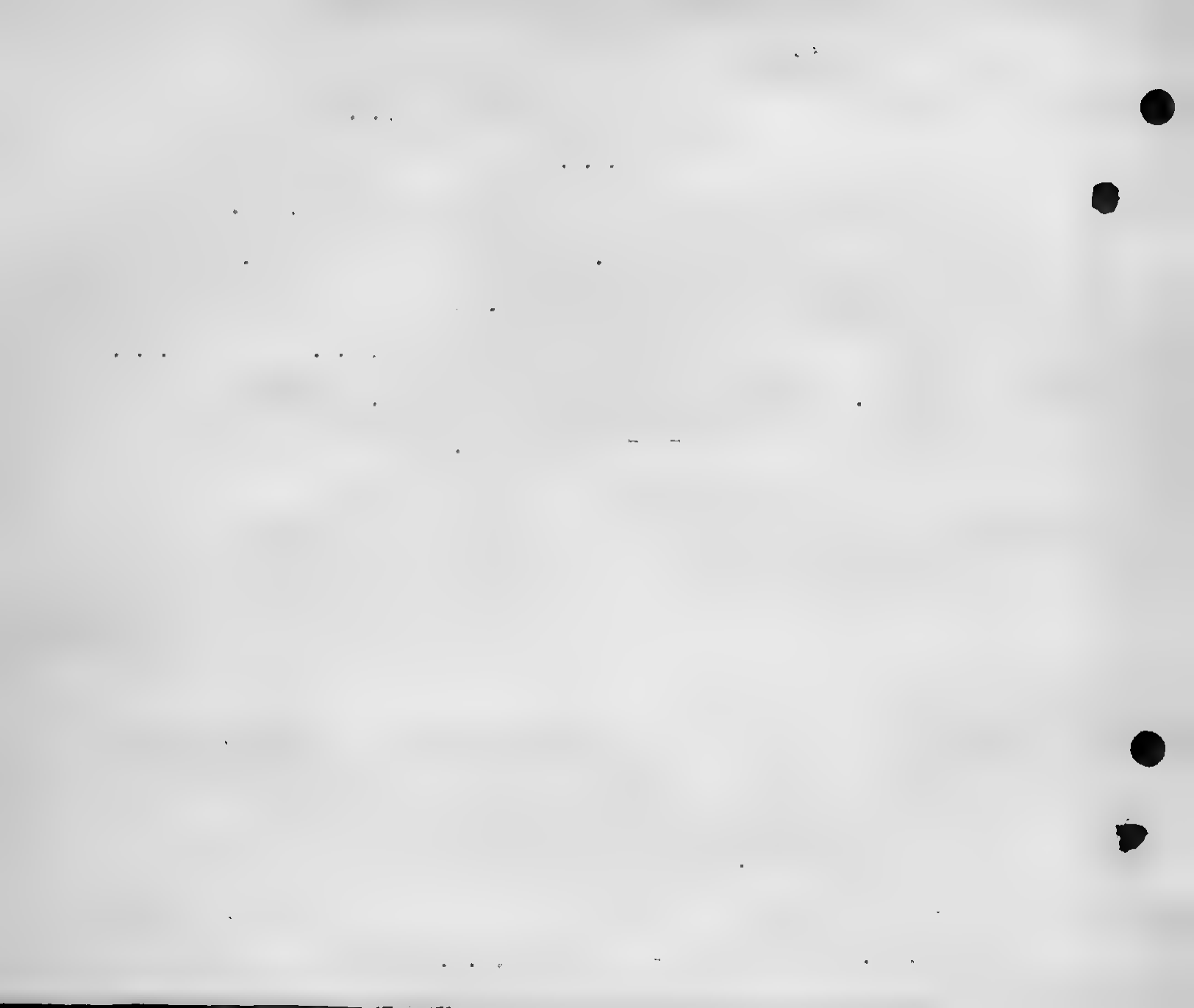
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be filled out by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/68

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10

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00913  
06905

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>D.O.A.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>47X-2</b> d. STREET ADDRESS <b>4415 Dexter Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>E.</b> Last <b>Schooley</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>21,</b> Year <b>1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Feb. 8, 1900</b>		9. AGE (In years last birthday) <b>61</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clarence E. Schooley</b>		14. MOTHER'S MAIDEN NAME <b>Lizzie L. Tiffany</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>World War 2</b>		16. SOCIAL SECURITY NO <b>579-01-5279</b>	
17. INFORMANT <b>Eleanor O. (wife)</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> 420.0 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 MINUTES</b> <b>YEARS -</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County, State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec 1954, 1959, to Jan 21, 1962</b> that (I) <del>last</del> saw the deceased alive on <b>Jan 12, 1962</b> and that death occurred at <b>12 noon</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard F. Manegold</b>		22b. DATE SIGNED <b>1-21-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard F. Manegold</b>		22d. ADDRESS <b>5255 Loughboro Rd Dist Columbia</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/24/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company-Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>JAN 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>William L. Hines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00916

00914

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>CONGRESSIONAL MANOR Sanitarium</u>		d. STREET ADDRESS <u>3819 1/2 Woodley Rd. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY Elizabeth SCRIBNER</u>		4. DATE OF DEATH Month Day Year <u>JAN 12 1962</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 8 1879</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUMMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>District of Columbia</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George W. Allen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Poore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-46-2519A</u>	
17. INFORMANT <u>Mrs Thelma Bonini</u>		Address <u>East Naples Fla.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Cerebral Edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebrovascular Hemorrhage</u> DUE TO <u>1-1 hypertension</u> (c) <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days - 10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-1-60</u> 19 <u>60</u> to <u>1-12</u> 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Jan 11</u> 19 <u>62</u> and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>J. A. Gannon</u> M.D.		22b. DATE SIGNED <u>1/12/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. GANNON D.M.D.</u>		22d. ADDRESS <u>3141-34th St. N.W. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/15/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph F. Birchson</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '62</u>	
ADDRESS <u>Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be completed by the hospital or attending physician. Part 2 may be completed by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If an-please remove carbon papers from pages 1 and 2, should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00915  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN b. <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>8619 Flower Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Silena</u> <u>LE</u> <u>Seek</u>		4. DATE OF DEATH Month Day Year <u>Jan</u> <u>20</u> <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>Nov. 18. 61</u>	
9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>5</u> IF UNDER 24 HRS.: Hours <u>3</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE County & State, or foreign country <u>Montgomery, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Everett R. Seek</u>		14. MOTHER'S MAIDEN NAME <u>Carol M. Ford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Washington San. &amp; Hospital Record</u>	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Congenital heart disease</u> <u>754.2</u> DUE TO (b) <u>Transposition of great vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Congenital heart failure</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29, 1961</u> , to <u>Jan. 20, 1962</u> ; that (I) (we) last saw the deceased alive on <u>Jan. 20, 1962</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Winston E. Cochran M.D.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>WINSTON E. COCHRAN</u>		22d. ADDRESS <u>800 Randolph Drive Silver Spring</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/23/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Adelphi Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>JAN 23 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. L. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

STATE OF MARYLAND  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00916

00908

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Bethesda Hospital</u>		d. STREET ADDRESS <u>13824 Warner St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>He</u> Last <u>Seiders</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>7</u> Year <u>1962</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1877</u> yrs
9. AGE (in years last birthday) <u>84</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>	
11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Hamby Seiders</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Ann Lillie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Reginald W. Seiders</u> Address <u>same as above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-6-1962</u> to <u>1-7-1962</u> , that (I) (we) last saw the deceased alive on <u>1-7-1962</u> , and that death occurred at <u>5:30 PM</u> from the causes and on the date stated above			
22a. SIGNATURE <u>Sarah E. Glover</u> M.D.		22b. DATE SIGNED <u>1/7/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>SARAH E. GLOVER</u>		22d. ADDRESS <u>10128 Cedar Lane, Kensington, Md.</u>	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>1-8-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Spring Green Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Spring Green, Wisconsin</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u>	
		25b. REGISTRAR'S SIGNATURE <u>W. L. G. Glover</u>	

CORONER NOTIFIED AND WILL APPROVE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled in by the attending physician and completely filled in by the funeral director. Page 2 may be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MONTGOMERY COUNTY, MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN IS <b>53 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U. S. Naval Hospital, Bethesda, Maryland</b>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				f. STREET ADDRESS <b>1717 Poplar Lane NW</b>			
3. NAME OF DECEASED (Type or print) <b>George Leonard Shane</b>				4. DATE OF DEATH <b>January 1, 1962</b>				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 18, 1903</b>		9. AGE (In years last birthday) <b>58 yrs.</b>		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Naval Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George L. Shane</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Welch</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>WIFE: Mrs. Eva D. Shane, Same as #2</b>				18. INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Insufficiency</b> DUE TO (b) <b>Metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Carcinoma of Liver</b> DUE TO (c) <b>Carcinoma of Liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (This hospital) attended the deceased from <b>Nov. 8, 1961</b> to <b>Jan. 1, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 1, 1962</b> , and that death occurred at <b>4:17 PM</b> on the causes and on the date stated above.											
22a. SIGNATURE <b>William P. Baker</b>				22b. DATE SIGNED <b>January 2, 1962</b>				22c. PHYSICIAN'S NAME (Type) <b>WILLIAM P. BAKER, LT MC USN</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>Jan. 4, 1962</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>			
23d. LOCATION (City, town or county) <b>Arlington, Virginia</b>				23e. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23f. LOCATION (City, town or county) <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Gawlers Sons Inc.</b>				24a. REC'D BY REGISTRAR <b>JAN 3 '62</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			
24c. ADDRESS <b>1756 Penn. Ave. NW, WDC</b>				24d. DATE <b>JAN 3 '62</b>				24e. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
00918 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00918									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN b. <b>20 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3404 Shepp Shepherd Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>2 Chevy Chase</b> d. STREET ADDRESS <b>3404 Shepherd Street</b> e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
3. NAME OF DECEASED (Type or print) <b>Edward Mead Sherman</b>					4. DATE OF DEATH <b>Jan. 16 1962</b>				
5. SEX <b>Male</b>					6. COLOR OR RACE <b>White</b>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH <b>July 15, 1900</b>				
9. AGE (In years last birthday) <b>61</b> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired store manager</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Safeway chain</b>				
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Charles Thatcher Sherman</b>					14. MOTHER'S MAIDEN NAME <b>Jeanette G. Cropp</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16. SOCIAL SECURITY NO. <b>577-05-1674</b>				
17. INFORMANT <b>Mrs. Christine E. Sherman Item #2</b>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) <b>History of previous coronary disease</b> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.) 20c. TIME OF INJURY Month Day Year <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Frank J. Broschart</b> EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>1-16-62</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>1-18-62</b>				
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>					22d. LOCATION (City, town, or country) (State) <b>Prince Georges Maryland</b>				
23. FUNERAL DIRECTOR <b>R. A. Ziska</b> ADDRESS <b>Georgia Ave. Warner E. Pumphrey, Inc. Silver Spring, Md.</b>					24a. REC'D BY REGISTRAR <b>JAN 19 '62</b> 24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>				





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00911

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Kensington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10,314 Armory Ave.</b>				d. STREET ADDRESS <b>10,314 Armory Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Arad</b> Middle <b>Benjamin</b> Last <b>Shipp</b>				4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>1962</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 7, 1898</b>	9. AGE (in years last birthday) <b>63</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federal Reserve System</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Shipp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Turpin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Lola A. Shipp 10,314 Armory Ave. Kensington Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion (IHD)</b> 4-2-62 DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1953</b> to <b>Jan 4, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan 6, 1962</b> , and that death occurred at <b>3:30 PM</b> from the causes and on the date stated above							
22a. SIGNATURE <b>Samuel Allen, M.D.</b>				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>1/7/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>SAMUEL ALLEN, M.D. Kensington Maryland</b>				22d. ADDRESS <b>10,407 Fawcett St. Kensington, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-9-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey Inc.</b>				25a. REC'D BY REGISTRAR <b>JAN 11 '62</b>		25b. REGISTRAR'S SIGNATURE <b>L. S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00920

00912

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY Night <b>8 hrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>Box 264</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHARLES ROGER SHOEMAKER</b>		4. DATE OF DEATH Month <b>1</b> Day <b>8</b> Year <b>1962</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-86</b>	
9. AGE (In years 'IF UNDER 1 YEAR' lay birthday) <b>75</b> yrs		10. AGE (In years 'IF UNDER 24 HRS.' Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>nursery</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Shoemaker</b>		14. MOTHER'S MAIDEN NAME <b>Betty Myers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>215-18-0136</b>	
17. INFORMANT <b>hospital records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BILE PERITONITIS</b> <b>588</b> X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RUPTURED GALL BLADDER</b> <b>XXXX</b> (c) <b>BILATERAL BRONCHOPNEUMONIA</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (.) (this hospital) attended the deceased from <b>JAN. 8</b> 19 <b>62</b> , to ....., 19....., that (I) (we) last saw the deceased alive on <b>JAN. 8</b> 19 <b>62</b> , and that death occurred at .....M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur F. Woodward</b> 22c. PHYSICIAN'S NAME (Type) <b>ARTHUR F. WOODWARD, M.D.</b> 22d. ADDRESS <b>Rockville, Maryland</b>			
22b. DATE SIGNED <b>1/10/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>1-12-62</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Laytonsville</b> ADDRESS <b>Laytonsville, Md.</b>			
23d. LOCATION (City, town or county) (State) <b>Laytonsville, Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>			
25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Thorne</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be filed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00921

CERTIFICATE OF DEATH

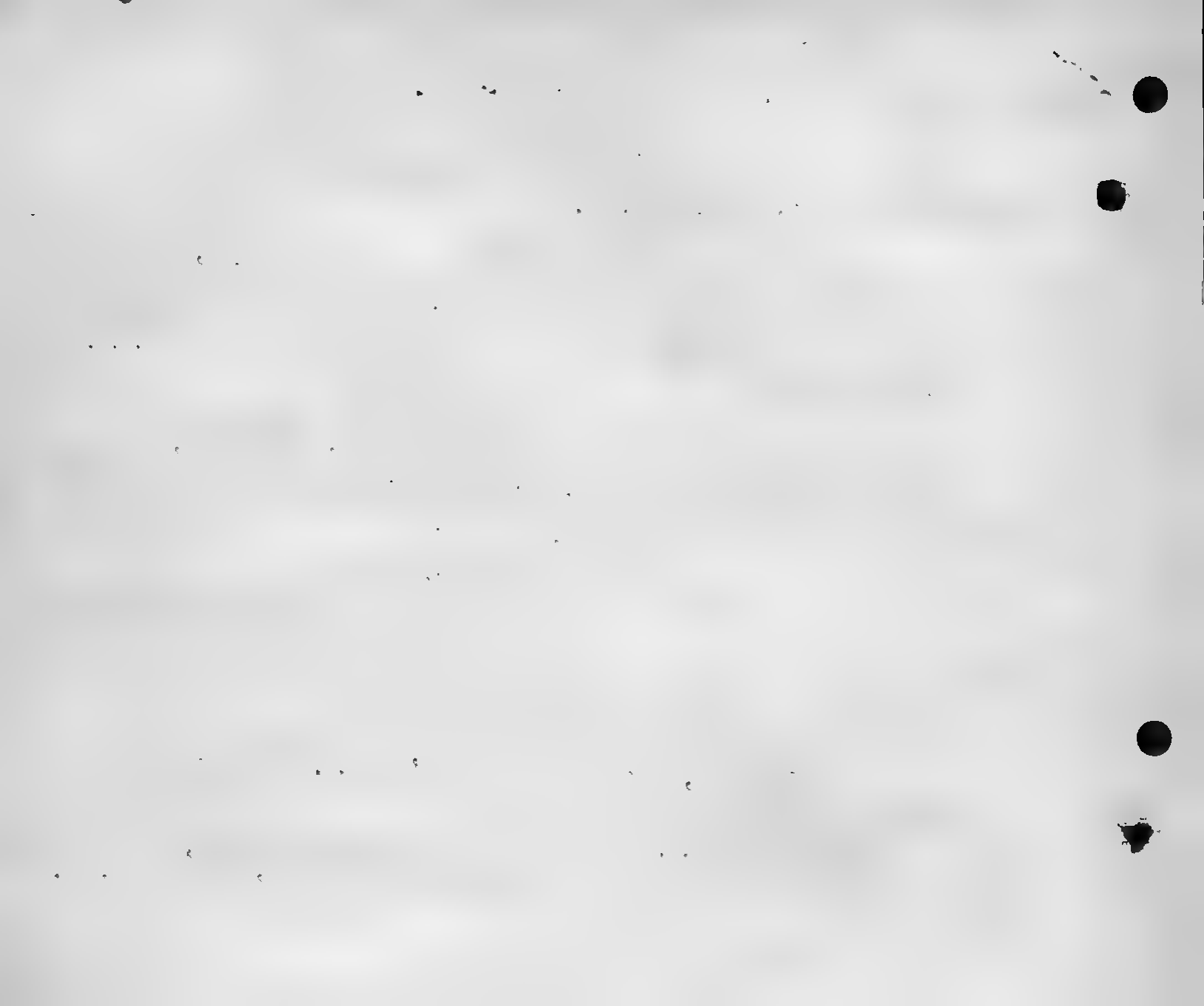
00913

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY N 1b <u>Thrs. Home</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>13014 - Atlantic Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Lucille A. M. Sievers</u>		4. DATE OF DEATH <u>Jan. 22 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>3/8/1942</u>	9. AGE (In years last birthday) <u>42</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Montana</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Stephen L. Murphy</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Strier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>536-07-6395</u> John R. Sievers-Husanbd-same 2d	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>18 mos.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. _____ p.m. _____	Month, Day, Year _____ 19____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1961</u> to <u>Jan. 22, 1962</u> that (I) <u>had</u> last saw the deceased alive on <u>22 Jan. 1962</u> and that death occurred <u>10:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Brunton</u>		22b. DATE SIGNED <u>Jan 22 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Brunton</u>		22d. ADDRESS <u>4743 Bradley Blvd. Ch. H. B. Md</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Cremation</u> <u>1/25/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>JAN 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>L. Thomas</u>	

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00923

CERTIFICATE OF DEATH

Reg. Dist. No.

00915

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Bethesda, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6533 ELGIN LANE</b>		d. STREET ADDRESS <b>6533 Elgin Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>MARIE</b> Middle <b>SILVER</b> Last		4. DATE OF DEATH Month <b>1</b> Day <b>5</b> Year <b>1962</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 15, 1886</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>DAVID EISENBERG</b>	
14. MOTHER'S MAIDEN NAME <b>DIANA STEINBERG</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT Address <b>BETH. MD.</b> <b>JACK SILVER 6533 ELGIN LANE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Coronary Arterio-sclerotic Heart Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>62 Days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 4, 1961</b> , to <b>Jan 5, 1962</b> , that I last saw the deceased alive on <b>Jan 3, 1962</b> , and that death occurred at <b>5:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1835 EYE ST N.W.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>William S. Miller</b> M.D.		DATE SIGNED <b>WASH. C D.C.</b>	
PHYSICIAN'S NAME (Type) <b>William S. Miller M.D.</b>		DATE SIGNED <b>WASH. C D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-7-62</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY + SONS - 3501-14th ST. NW</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 9 '62</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be detached by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda,</b> d. STREET ADDRESS <b>7600 Hemlock St., Bethesda</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Hannah M. Skerritt</b>		4. DATE OF DEATH Month Day Year <b>Jan. 7 19 62</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>Aug. 10, 1877</b>	
9. AGE (In years last birthday) <b>84</b> yrs		10. IF UNDER 1 YEAR Months Days <b>84</b>	
11. IF UNDER 24 HRS. Hours M n. <b>84</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Skerritt</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Jane L. Seaman</b>		Address <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal bleeding, abd. tumor, cholesterol</b> 239X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (e): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 1960</b> to <b>6 Jan 1962</b> , that (I) (we) last saw the deceased alive on <b>6 Jan 1962</b> , and that death occurred at <b>7 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert Martin Jr</b> M.D.		22b. DATE SIGNED <b>7 Jan 62</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT MARTIN JR</b>		22d. ADDRESS <b>5029 Bethesda Ave Bethesda Md</b>	
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 10, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenfield Cem.,</b>		23d. LOCATION (City, town or county) (State) <b>Hempstead, New York</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda 14, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 9 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Cliff &amp; Kline</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00917

00925

<b>1 PLACE OF DEATH</b> COUNTY <u>Maryland</u> <u>Kensington Md</u> <b>MARYLAND</b> b. CITY OR TOWN <u>Kensington</u> (Corporate limits, write) c. LENGTH OF STAY in 1b RURAL and give nearest town)				<b>2 USUAL RESIDENCE</b> (Where deceased lived if institution: Residence before admission) STATE <u>D.C.</u> COUNTY <u>Washington, D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>5429 Conn. Ave. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Slattery, Mabel G. Mrs</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>1-15-62</u> Jan Monday 1962 Month Day Year			
<b>5 SEX</b> <u>Female</u>		<b>6 COLOR OF RACE</b> <u>White</u>		<b>7 MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7/1/84</u>	
<b>9 AGE</b> (In years last birthday) <u>77</u> yrs.		<b>10 UNDER 1 YEAR</b> Months Days Hours Min.		<b>11 BIRTHPLACE</b> (State or foreign country) <u>USA Ohio</u>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Secretary D.C. Government</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>			
<b>13. FATHER'S NAME</b> <u>Gates Frank</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Wilburger Amanda</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO</b> <u>578-01-9646A</u>			
<b>17. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, LOBAR, RT LOWER LOBE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>490X</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBROVASCULAR ACCIDENT</u>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month Day Year Hour a. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street office bldg etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>SEPT. 1959</u> <b>to</b> <u>JAN. 15, 1962</u> <b>that I last saw the deceased alive on</b> <u>JAN. 15, 1962</u> <b>and that death occurred at</b> <u>11:30 P.M.</u> <b>from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <u>6719 WILSON LANE BETHESDA 14, MD.</u> DATE SIGNED							
<b>ACTUAL SIGNATURE</b> <u>Stephen W. DeJeter</u> M.D.				<b>PHYSICIAN'S NAME (Type)</b> <u>STEPHEN W. DEJETER, M.D.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>burial</u>		<b>22b. DATE THEREOF</b> <u>1/18/62</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Prospect Hill Cemetery</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Washington, D.C.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>2801-14th St. N.W. was h. 9, D.C.</u> ADDRESS				<b>24a. RECORDING REGISTRATION</b> DATE <u>JAN 17 62</u>		<b>24b. REGISTRAR'S SIGNATURE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retroactively signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 00926

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>44 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9401 New Hampshire Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret Elizabeth Smart</u>		4. DATE OF DEATH Month Day Year <u>Jan. 28 1962</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25, 1872</u>
9. AGE (In years last birthday) <u>89 yrs</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Hammen</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Simonsen</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Stanley N. Smart</u> Address <u>9401 New Hampshire Ave. Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1957</u> to <u>Jan. 28, 1962</u> , that I last saw the deceased alive on <u>Jan. 27, 1962</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James L. Koubach</u> M.D.		DATE SIGNED <u>11/28/62</u>	
PHYSICIAN'S NAME (Type) <u>James L. Koubach</u>		<u>Hyattsville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-30-62</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>JAN 31 '62</u>	24b. REGISTRAR'S SIGNATURE <u>O. J. P. Pumphrey</u>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# CERTIFICATE OF DEATH

Item 9 Film 0305 1/19/62

00919

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>-</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>				d. STREET ADDRESS <b>2404 Wiseman Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Annie</b>		First <b>K</b>		Middle <b>Smith</b>		Last		4. DATE OF DEATH Month <b>January</b> Day <b>10</b> Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/10/85</b>		AGE (in years lost birthday) <b>77 1/2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Kensington, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US A</b>			
13. FATHER'S NAME <b>George Thornton Windham</b>				14. MOTHER'S MAIDEN NAME <b>Annie Kate Johnson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mr. Charles R. Smith Wheaton, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive heart disease &amp; liver failure</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 year</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary heart disease, anemia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Wheaton, Md.</b>		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/1/61</b> to <b>1/10/62</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/10/62</b> , 19 <b>62</b> , and that death occurred at <b>1:30</b> M. from the causes and on the date stated above									
22a. SIGNATURE <b>Patrick C. Jamerson</b> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <b>1-11-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Patrick C. Jamerson</b>				22d. ADDRESS <b>12020 Georgia Ave., Spring</b>					
23a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-13-62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		23d. LOCATION (City, town, or county) <b>Forest Glen, Md.</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Francis H. Barber</b>				ADDRESS <b>Laytonville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 15 '62</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00928

CERTIFICATE OF DEATH

00920

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN b. <b>18 1/2 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		d. STREET ADDRESS <b>5602 Randolph Road</b>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <b>Montgomery Bradford Smith</b>		4. DATE OF DEATH Month <b>January</b> Day <b>11</b> Year <b>1962</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 2, 1876/1867</b>		9. AGE (In years last birthday) <b>94</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Agustus W. Smith</b>		14. MOTHER'S MAIDEN NAME <b>Henritta Handy</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eugene Stubbs-Nephew-same 2d</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary + thrombosis</b> <b>420.1</b> DUE TO <b>anterior-cerebral vessel age</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>fell down stairs - 3 broken ribs</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)		20c. TIME OF INJURY Month, Day, Year <b>12/22/61</b>		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Silver Spring</b>		20g. (County) <b>Montgomery</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>9/15/61</b> to <b>1/10/62</b> , that (I) (we) last saw the deceased alive on <b>1/10/62</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Patrick C. Jameson</b>		22b. DATE SIGNED <b>1/11/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Patrick C. Jameson</b>		22d. ADDRESS <b>12020 Georgia St. Silver Spring Md.</b>		22e. REC'D BY REGISTRAR <b>Robert A. Pumphrey</b>		22f. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>		22g. DATE <b>JAN 15 '62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/13/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Cemetery</b>		23d. LOCATION (City, town or county) <b>Forest Glen, Maryland</b>		23e. (State) <b>Md.</b>		23f. (City or town) <b>Silver Spring</b>		23g. (County) <b>Montgomery</b>		23h. (State) <b>Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24b. ADDRESS <b>Bethesda, Maryland</b>		24c. DATE <b>JAN 15 '62</b>		24d. SIGNATURE <b>Robert A. Pumphrey</b>		24e. DATE <b>JAN 15 '62</b>		24f. SIGNATURE <b>Robert A. Pumphrey</b>		24g. DATE <b>JAN 15 '62</b>		24h. SIGNATURE <b>Robert A. Pumphrey</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2, and page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00929  
00921

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY MONTGOMERY	MARYLAND	a. STATE DISTRICT COLUMBIA	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRLAND	c. LENGTH OF STAY IN 1b 10/25/61-1-4-62	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	41X 3
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FAIRLAND NURSING HOME		d. STREET ADDRESS 4201-MASS. AVE.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print, First Middle Last) WILLIAM F SMITH		4. DATE OF DEATH 1-4-1962	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 26-1881
9. AGE (In years last birthday) 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK	11. BIRTHPLACE (County & State, or foreign country) New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FREDERICK SMITH	14. MOTHER'S MAIDEN NAME Josephine Dickerson	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES - Spanish-Amer.	16. SOCIAL SECURITY NO. 725-
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 450.0 IMMEDIATE CAUSE (a) <i>Generalized arteriosclerosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	21. I certify that (I) (this hospital) attended the deceased from Oct 29, 1961 to Jan 4, 1962 that (I) (we) last saw the deceased alive on January 4, 1962 and that death occurred at 11 PM, from the causes and on the date stated above.	
22a. SIGNATURE Boris Rabkin	22b. DATE SIGNED	22c. PHYSICIAN'S NAME (Type) BORIS RABKIN, M.D.	22d. ADDRESS 1019 University Blvd East Silver Spring Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 1-9-62	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NAT. CEM.	23d. LOCATION (City, town or county) (State) ARLINGTON, VIRGINIA
24. FUNERAL DIRECTOR'S SIGNATURE DEAL FUNERAL HOME		25a. REC'D BY REGISTRAR DATE JAN 8 '62	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be detached by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos. 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00930

00922

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Comus</b> c. LENGTH OF STAY IN b <b>14 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Comus</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Comus</b> d. STREET ADDRESS <b>-----</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Dorothy Ruth Spates</b>		4. DATE OF DEATH Month Day Year <b>1 29 1962</b>	
5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>1/21/1912</b> 9. AGE (in years; if under 1 year, last birthday) <b>50</b> yrs. Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D.C.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James E. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Bell Suddath</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-24-6559</b> 17. INFORMANT <b>George E. Spates</b> Address <b>Comus, Md.</b>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>425</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) Coronary thrombosis</b> DUE TO <b>(c) Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 HOURS</b> <b>4 YEARS</b> <b>5 YEARS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>-----</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10.1.30</b> ..., 19 <b>49</b> , to <b>1/29</b> ..., 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>1/29</b> , 19 <b>61</b> , and that death occurred at <b>-----</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>1/29/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>James. P. Kerr</b>		22d. ADDRESS <b>DAMASCUS, MD.</b>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/1/62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>		23d. LOCATION (City, town or county) (State) <b>Beallsville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		25. REC'D BY REGISTRAR <b>FEB 2 '62</b> ADDRESS <b>Barnesville, Md.</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>			

9220-4x-615



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be completed by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00931

00923

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN b. <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery General Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Osborn</u> Middle <u>N</u> Last <u>Stabler</u>		<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>17</u> Year <u>1962</u>	
<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>12/11/1901</u>	
<b>9. AGE</b> <u>60</u> yrs. <b>10. IF UNDER 1 YEAR</b> Months _____ Days _____ <b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>farmer</u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>	
<b>13. FATHER'S NAME</b> <u>Newton Stabler</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Hallowell</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>unknown</u>		<b>16. SOCIAL SECURITY NO.</b> <u>220 34 7932</u>	
<b>17. INFORMANT</b> <u>Hospital Records</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding peptic ulcer, stomach</u> Conditions, if any, which gave rise to immediate cause (b) <u>Portal vein thrombosis</u> (c) <u>Primary Carcinoma of liver</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 wk.</u> <u>2 wk.</u> <u>8 mo.</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18) _____	
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 8, 1961</u> <b>to</b> <u>1/17/62</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/17/62</u> <b>and that death occurred at</b> <u>8 P.M.</u> <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>C. H. Ligon</u>		<b>22b. DATE SIGNED</b> <u>1/18/62</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>C. H. LIGON, M.D.</u>		<b>22d. ADDRESS</b> <u>SANDY SPRING, MD.</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Jan. 19 1962</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Friends</u>		<b>23d. LOCATION</b> (City, town or county) <u>Sandy Spring</u> (State) <u>Md.</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Francis H. Barber</u>		<b>24b. ADDRESS</b> <u>Laytonsville, Md.</u>	
<b>25a. REC'D BY REGISTRAR</b> <u>JAN 22 1962</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles A. Harris</u>	
<b>DATE</b> <u>JAN 22 1962</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>Charles A. Harris</u>	



10-111504 2-9-58  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00932 00924

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) <table border="1"> <tr> <td>a. STATE <u>Md</u></td> <td>b. COUNTY <u>Montgomery</u></td> </tr> <tr> <td colspan="2">c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u></td> </tr> <tr> <td colspan="2">d. STREET ADDRESS <u>12814 Valleywood Drive</u></td> </tr> </table>		a. STATE <u>Md</u>	b. COUNTY <u>Montgomery</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		d. STREET ADDRESS <u>12814 Valleywood Drive</u>	
a. STATE <u>Md</u>	b. COUNTY <u>Montgomery</u>								
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>									
d. STREET ADDRESS <u>12814 Valleywood Drive</u>									
<b>3. NAME OF DECEASED</b> (Type or print) <u>Laura Anne Stambaugh</u>		<b>4. DATE OF</b> Month <u>Jan.</u> Day <u>16</u> Year <u>1962</u>							
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8-1-59</u>						
<b>9. AGE</b> (In years last birthday) <u>2</u> yrs <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>2</u> Days <u>2</u></td> <td>Hours <u>2</u> Min. <u>2</u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>2</u> Days <u>2</u>	Hours <u>2</u> Min. <u>2</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>NONE</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, DC</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months <u>2</u> Days <u>2</u>	Hours <u>2</u> Min. <u>2</u>								
<b>13. FATHER'S NAME</b> <u>Thomas H. Stambaugh</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Stephenson</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>NONE</u> <b>17. INFORMANT</b> <u>Pl. chart</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>viral infection</u> Conditions, if any, which gave rise to immediate cause (b) <u>Overwhelming toxemia due to (a)</u> (c), stating the underlying cause last. <u>mental retardation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>mental retardation</u>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>48 hrs</u>							
<b>20a. TIME OF INJURY</b> Month, Day, Year Hour <u>11</u> a.m. <u>19</u> p.m.		<b>20b. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
<b>20c. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>114</u>		<b>20d. (City or town)</b> <u>116</u> <b>(County)</b> <u>116</u> <b>(State)</b> <u>116</u>							
<b>21. I certify that (I) (this hospital) attended the deceased from 1/14 to 1/16, 1962, that (I) (we) last saw the deceased alive on 1/16, 1962, and that death occurred at 11:16 a.m. from the causes and on the date stated above.</b>									
<b>22a. SIGNATURE</b> <u>Herbert H. Diamond</u>		<b>22b. DATE SIGNED</b> <u>1/17/62</u>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>H.H. DIAMOND</u>		<b>22d. ADDRESS</b> <u>911-Silver Spring Ave S.S. Md</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1-19-62</u>							
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Arlington</u> <b>(State)</b> <u>Virginia</u>							
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Warner E. Humphrey</u>		<b>25a. REC'D BY REGISTRAR</b> <u>DATE JAN 22 '62</u>							
<b>25b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>		<b>25c. ADDRESS</b> <u>Georgia Ave, Silver Spring, Md.</u>							

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours of death. It may be filled out by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. It may be filled out by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. It may be filled out by the hospital or attending physician.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00933 - Item 9, 11m G306 2/2/62 - 1wk 00925

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>7101 Holly Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>ERNEST CRAVATH STEWARD</u>		DATE OF DEATH Month <u>Jan</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2, 1871</u>
9. AGE Year <u>91</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S. Government Chattanooga, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas C. Steward</u>		14. MOTHER'S MAIDEN NAME <u>Lydia Farmer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes W.W.I.</u>		16. SOCIAL SECURITY NO. <u>579-32 4903A</u>	
17. INFORMANT <u>Mrs. Arthur C. Steward, 2210 F.D. Rd. D.C.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 450.0 DUE TO <u>Senile Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1942</u> to <u>28 Jan 1962</u> , that (I) (we) last saw the deceased alive on <u>25 Jan 1962</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>H. B. Queen</u>		22b. DATE SIGNED <u>28 Jan 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. B. QUEEN</u>		22d. ADDRESS <u>7112 Willow Ave Takoma Park, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 31, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur C. Steward</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur C. Steward</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1

2

3

4

U.S. DEPARTMENT OF HEALTH DIVISION OF STATISTICS AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00934			
00926			
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Annandale</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Annandale</b>	
c. LENGTH OF STAY in lb <b>7 days</b>		d. STREET ADDRESS <b>910 Bruce Lane</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Doris Marie Stover</b>		4. DATE OF DEATH Month Day Year <b>January 21 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>25 June 1927</b>	
9. AGE (In years last birthday) <b>34 yrs</b>		10. IF UNDER 1 YEAR Months Days <b>34 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Leo Montgomery</b>	
14. MOTHER'S MAIDEN NAME <b>Violet Nutwell</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>Husband Donald L. Stover</b>		17. INFORMANT <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary insufficiency</b> Conditions, if any, which gave rise to immediate cause (b) <b>pleural + pericardial metastases</b> (c) <b>carcinoma of the breast</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>3 days</b> <b>6 mos</b> <b>20 mos</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>14 January, 1962</b> , to <b>21 January, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>21 January, 1962</b> , and that death occurred at <b>1620 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Barclay M. Shepard</b> M.D.		22b. DATE SIGNED <b>Jan. 22, 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>BARCLAY M. SHEPARD LT MC USN</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-24-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Marys' Church Cemetery Bryontown, Maryland</b>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HUNT Funeral Home, Waldorf, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE 23 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Wm. S. Pinn</b>			





00935

## 011927

- |   |  |                                 |                         |                            |
|---|--|---------------------------------|-------------------------|----------------------------|
| 23. FUNERAL DIRECTOR<br><i>H. H. Kline</i>        |  | ADDRESS                         | 24a. REC'D BY REGISTRAR | 24b. REGISTRAR'S SIGNATURE |
| H. H. Kline, Inc., 737 N. W. 1st St., Miami, Fla. |  | 1557 Wisconsin Ave., Beth., Md. | DATE JAN 8 '62          | <i>Cynthia S. Thomas</i>   |

VS. A15ME

5M 7/59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00936

00928

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SURBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>Montgomery, 4700 + 4th St.</b>	
3. NAME OF DECEASED (Type or print) <b>EMMA B. SWIGETT</b>		4. DATE OF DEATH Month <b>Jan</b> , Day <b>2</b> , Year <b>1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/20/1866</b>	
9. AGE (In years, if UNDER 1 YEAR, IF UNDER 24 HRS. last birthday) <b>95</b> yrs.		10. MONTHS <b>9</b> DAYS <b>2</b> HOURS <b>12</b> MIN.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) <b>INDIANA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN BAIN</b>		14. MOTHER'S MAIDEN NAME <b>BETHSHEBA GOSS</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>KIVETT, MARTINSVILLE, IND.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause, per (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO <b>(Possible pulmonary embolism)</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of rt. hip, 9th 1961 when she fell at home</b> (c) <b>It fell at home + fractured hip.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Fracture of rt. hip, 9th 1961 when she fell at home</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER.) <b>It fell at home + fractured hip.</b>		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9th 1961</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Wash</b> (County) <b>DC</b> (State) <b>DC</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>1961</b> to <b>2 Jan</b> , 1962 that (I) (we) last saw the deceased alive on <b>1 Jan</b> , 1962, and that death occurred at <b>Home</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Harry A. Horstman</b>		22b. DATE SIGNED <b>2 Jan 1962</b>	
22c. PHYSICIAN'S NAME (Type) <b>HARRY A. HORSTMAN</b>		22d. ADDRESS <b>1835 EYE ST., N.W., WASH., D.C.</b>	
23a. BURIAL OR CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN 3, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>SOUTH PARK CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>MARTINSVILLE, INDIANA</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons</b>		25a. REC'D BY REGISTRAR <b>JAN 4 '62</b>	
ADDRESS <b>1756 PA. AVE N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Chas W. J. Fraw</b>	



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 9,60

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00937 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00929

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Guthrie</u> c. LENGTH OF STAY in lb <u>5 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>105 Russell Ave - Dr. Schumaker's Office</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Res denote before admission) a. STATE <u>md</u> b. COUNTY <u>mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Selma Spring</u> d. STREET ADDRESS <u>4509 Beamon Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Deborah Christine Taylor</u>				<b>4. DATE OF DEATH</b> Day <u>24</u> Month <u>Jan</u> Year <u>1962</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-27-61</u>	
<b>9. AGE</b> (In years last birthday) <u>4</u> yrs. <b>UNDER 1 YEAR</b> <u>4</u> Months <u>27</u> Days				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Infant</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>md</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.C</u>			
<b>13. FATHER'S NAME</b> <u>Joel Taylor</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Christine Bogley</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>None</u>			
<b>17. INFORMANT</b> <u>Christine Taylor (mother)</u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO (b) <u>upper Respiratory Infection</u> (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part I. of item 18.)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>				<b>22. LOCATION</b> (City, town, or country) <u>Rockville, Maryland</u>			
<b>23. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>				<b>24. REC'D BY REGISTRAR</b> <u>Jan 24 1962</u>			
<b>25. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>26. DATE THEREOF</b> <u>1/26/62</u>			
<b>27. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>				<b>28. REGISTRAR'S SIGNATURE</b> <u>C. Ann E. Kline</u>			

2073212153



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00938

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00938

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Spencerville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg General Hosp</u>		d. STREET ADDRESS <u>Ind R-198</u>	
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Thomas</u>	4. DATE OF DEATH <u>Jan 2 1962</u>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880 8/1</u>
9. AGE (In years last birthday) <u>81</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Va</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	13. FATHER'S NAME <u>Jack Sayles</u>	14. MOTHER'S MAIDEN NAME <u>Unknown</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)
16. SOCIAL SECURITY NO. <u>Informant</u>	17. ADDRESS <u>Archie Thomas (Son) Steun 2</u>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hrs</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic valvular heart disease + hypertension</u>		DUE TO <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20d. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/7/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. James Baptist.</u>		22d. LOCATION (City, town, or country) (State) <u>Bealeton, Va.</u>	
23. FUNERAL DIRECTOR <u>Robert L. Surwode</u> ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 11 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>		DATE <u>1-2-61</u>	

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 00939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

011931

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 9,60

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN (b) <u>4 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>24 E. Montgomery Ave. - apt X</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>24 E. Montg. Ave. apt X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Carmy Lee Tonker</u>		<b>4. DATE OF DEATH</b> Last <u>Jan</u> Month <u>12</u> Day <u>1962</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OF RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>8-31-17</u> <b>9. AGE</b> (In years last birthday) <u>44</u> yrs. IF UNDER 1 YEAR: Months <u>4</u> Days <u>4</u> IF UNDER 24 HRS.: Hours <u>4</u> Min. <u>4</u>			
<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Unknown</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>230-285083</u> <b>17. INFORMANT</b> <u>Martin Tonker - Son</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> (b) <u>Chronic Valvular Heart Disease</u> (c) <u>Due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u>				<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour a.m. <u>11</u> p.m. <u>4</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> <b>20f. (City or town)</b> <u>Rockville</u> (County) <u>Montgomery</u> (State) <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschert</u> <b>EXAMINER'S NAME (Type)</b> <u>FRANK J. BROSCHE</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>1-12-62</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>1/16/62</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Forest Oak</u>		<b>22d. LOCATION</b> (City, town, or country) <u>Gaithersburg, Md.</u> (State) <u>Md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>John W. Wheeler</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>John W. Wheeler</u>			
<b>23. FUNERAL DIRECTOR</b> <u>1331 E. Montgomery Ave. Rockville, Md.</u>		<b>24c. DATE</b> <u>JAN 17 '62</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00940

Item 6 Film Q306 2/5/62 iwk

CERTIFICATE OF DEATH

00932

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>1</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BEL PEE Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington DC</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington DC</b> d. STREET ADDRESS <b>1614 Good Hope Rd SE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PAULINE</b> First Middle Last <b>WAGLE Troop</b>		4. DATE OF DEATH Month Day Year <b>11/30/62</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-20-1888</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Latvia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>O. Benjamin Troop</b>		Address <b>1614 Good Hope Rd SE DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of The Stomach</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>151X</b> DUE TO (a), stating the underlying cause last, (c) <b>8 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dehydration, Decubitus ulcers</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <b>11:55</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11/5</b> , 19 <b>61</b> , to <b>11/30</b> , 19 <b>62</b> , that (I) (we) last saw the deceased alive on <b>11/29</b> , 19 <b>62</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Max G. Sherer</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>MAX G. SHERER MD</b>	
22b. DATE SIGNED <b>1/30/62</b>		22d. ADDRESS <b>2025 EAST West Hwy Silver Spring Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1/31/1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>S.E. HEBREW Cem.</b>		23d. LOCATION (City, town or county) (State) <b>WASH. DC</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Halberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>JAN 31 '62</b>	
ADDRESS <b>4217-9th St. N.W.</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. S. Frame</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00941

00933

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>133 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>1354 Somerset Place, N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Owen Austin Troy</u>		<b>4. DATE OF DEATH</b> <u>January 18, 1962</u>	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Negro</u>	
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>November 3, 1899</u>		<b>9. AGE</b> (If years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Mins. _____	
<b>10a. USUAL OCCUPATION</b> Give kind of work done during most of working life, even if retired) <u>Minister</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Church</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>California</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Theodore W. Troy</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Juliette Washington</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> <u>Unavailable</u> <b>17. INFORMANT</b> <u>The Medical Record</u> Address _____	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hemorrhagic pneumonitis</u> <u>203 X</u> DUE TO <u>Multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4-5 days</u> <u>8 months</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____	
<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. _____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 7, 1961</u> to <u>January 18, 1962</u> , that <u>no</u> (we) last saw the deceased alive on <u>January 18, 1962</u> , and that death occurred at <u>6:00 AM</u> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Geo. H. Porter III, MD</u>		<b>22b. DATE SIGNED</b> <u>January 18, 1962</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>George H. Porter III, MD</u>		<b>22d. ADDRESS</b> <u>The Clinical Center, National Institutes of Health, Bethesda 14, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>1/22/62</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Lincoln Memorial Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) <u>Suitland, Maryland</u> (State) _____	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert L. Plummer</u>		<b>25a. REC'D BY REGISTRAR</b> <u>25b. REGISTRAR'S SIGNATURE</u> <u>3015 12th St. N. E.</u> <u>JAN 22 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)  
15M 9/60



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>20 yrs</u>		d. STREET ADDRESS <u>2114 Seminary Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2114 Seminary Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susie Maud Tucker</u>		4. DATE OF DEATH <u>Jan 13 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1886</u>
9. AGE (In years, last birthday) <u>75</u> yrs.		10. AGE (In years, last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N. S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>David Hampton Pugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stuart Lewis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Francis P. Mann</u>		Address <u>2408 Seminary Rd Silver Spring md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Carcinoma of lower intestinal tract with metastases</u> DUE TO <u>metastases</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Bauschert</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BAUSCHERT</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR <u>The S. H. Hines Company-Washington, D.C.</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please e. the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A15ME  
SM 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00943

00935

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
c. LENGTH OF STAY IN TB <u>3 yrs</u>				d. STREET ADDRESS <u>18806 Lamer Dr - Apt 104</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8806 Lamer Dr - Apt 104</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Arthur Jack Turner</u>				4. DATE OF DEATH <u>Jan 30 1962</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 10 - 1910</u>	
9. AGE (in years lost birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Gov. RETIRED Claim Dept</u>		11. BIRTHPLACE (State or foreign country) <u>Monette Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Turner</u>				14. MOTHER'S MAIDEN NAME <u>Maudie Csee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES APR 1942 - NOV 1945</u>				16. SOCIAL SECURITY NO. <u>YES</u>			
17. INFORMANT <u>Janet Turner (wife)</u> Address <u>Stem 2</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asphyxia</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Aspiration of stomach contents</u> (c) <u>Chronic alcoholism</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Found dead sitting in lounge chair at home</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Found dead sitting in lounge chair at home</u>							
20c. TIME OF INJURY Month, Day, Year <u>2 Hour a.m. 1-30 1962</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) <u>Silver Spring</u> (County) <u>Monty</u> (State) <u>md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and, in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Broschert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-30-62</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>				22b. DATE THEREOF <u>2-1-62</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>				22d. LOCATION (City, town, or country) <u>Prince George Maryland</u>			
23. FUNERAL DIRECTOR <u>R.A. Ziska</u> ADDRESS <u>8434 Georgia Ave.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 2 '62</u>			
<u>Warner E. Pumphrey, Inc.</u> Silver Spring, Md.				24b. REGISTRAR'S SIGNATURE <u>Walter S. Kraus</u>			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH  
Found dead in chair at home



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be filled in by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00944  
00938  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall</u>		d. STREET ADDRESS <u>6111 Western Ave N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>SALLIE</u> First <u>Rebecca</u> Middle <u>UMSTEAD</u> Last		4. DATE OF DEATH <u>Jan. 30</u> 19 <u>62</u>	
5. SEX <u>Female</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
6. COLOR OR RACE <u>White</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life; even if retired) <u>C&amp;P Telephone Co.</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
8. DATE OF BIRTH <u>DEC 18-1886</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William J. Umstead</u>		14. MOTHER'S M maiden name <u>Elizabeth Austin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Anna M. Umstead - sister - Since</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO <u>444X</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) <u>ESSENTIAL HYPERTENSION</u> (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>FEMORAL THROMBOSIS (RIGHT LEG)</u>		19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> <u>NO</u> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>10</u> p.m. <u>10</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. City or town (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>AUGUST 22, 1961</u> , to <u>Jan. 30, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 30, 1962</u> , and that death occurred at <u>10:10 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry M. Lowden</u> M.D.		22b. DATE SIGNED <u>Jan. 30 - 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY M. LOWDEN</u>		22d. ADDRESS <u>5206 Norman Dr. Cherry Chase, Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>2-27-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>		25. REC'D BY REGISTRAR <u>FEB 6 '62</u>	
ADDRESS <u>Bethesda, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00945

00937

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY (In days) <b>3 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs</b> d. STREET ADDRESS <b>10907 Fiesta Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Martyn Kirk Usilaner</b>		<b>4. DATE OF DEATH</b> Month <b>January</b> Day <b>8</b> Year <b>1962</b>	
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 17, 1953</b>	
<b>9. AGE</b> (In years last birthday) <b>8 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>11. BIRTHPLACE</b> (Country & State, or foreign country) <b>New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Hiram Usilaner</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Miriam Millman</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>The Medical Record</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Medullary Compression</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Hydrocephalus</b> DUE TO (c) <b>Craniopharyngioma</b>	
<b>19. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 day</b>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 year</b>	
<b>21. INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 years</b>		<b>22. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Hour a.m. <b>19</b> p.m. <b>11:32 PM</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 5, 1962</b> to <b>January 8, 1962</b> , that <b>we</b> (we) last saw the deceased alive on <b>January 8, 1962</b> , and that death occurred on <b>January 8, 1962</b> from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>Robert L. Fisher</b>		<b>22b. DATE SIGNED</b> <b>January 9, 1962</b>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <b>Robert L. Fisher</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1-10-62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>King David Memorial Garden</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Falls Church, Va.</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>B. Danzansky &amp; Sons</b>		<b>25a. REC'D BY REGISTRAR</b> <b>3501 14th St., NW</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>JAN 12 '62</b>		<b>25c. REGISTRAR'S SIGNATURE</b> <b>11:32 PM</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00946

Item 7-111m-630-1/20/62 iwk

00938

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>5130 Conn. Ave., N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Dorothy Ellen Utz</b>		4. DATE OF DEATH <b>January 18, 1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEV <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/5/08 05</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTING CLERK U.S. Govt.</b>		11. BIRTHPLACE (County & State or foreign country) <b>Washington, D. C.</b>	
13. FATHER'S NAME <b>A. Thomas Utz</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Ribble</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>Brother, David E. Utz - same as above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>INTRACEREBRAL HEMORRHAGE</b> DUE TO <b>Ruptured Aneurysm, Rt middle CEREBRAL ARTERY.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m. 20d. INJURY OCCURRED While at work Not While at work 20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc. 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>April, 1941 to Jan. 18, 1962</b> that (I) (we) last saw the deceased alive on <b>Jan. 18, 1962</b> and that death occurred at <b>12:35 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Gilbert B. Rade</b>		22b. DATE SIGNED <b>1/18/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>GILBERT B. RADE</b>		22d. ADDRESS <b>3900 MILITARY RD., N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>JAN. 22, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. E. Humphrey</b>		25a. REC'D BY REGISTRAR <b>55</b> DATE <b>JAN 22 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

Dr. Broschart notified

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.





**00947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00939

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN b. <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>4900 Battery Lane - Apt 314</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Wis.</u> b. COUNTY <u>Fond Du Lac</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fond Du Lac</u> d. STREET ADDRESS <u>47 Oaklawn Ave</u>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Sophia Cornelius Van Pelt</u> First Middle Last <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY _____		<b>4. DATE OF DEATH</b> <u>Jan 16 1962</u> Month Day Year <b>9. AGE</b> (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____ <b>11. BIRTHPLACE</b> (State or foreign country) <u>Wis.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> <b>13. FATHER'S NAME</b> _____ <b>14. MOTHER'S MAIDEN NAME</b> _____	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> _____ <b>17. INFORMANT</b> <u>Wm K Van Pelt (husband)</u> Address _____		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>430.1</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____ (b) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (c) _____	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/></b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) _____		<b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town)</b> _____ (County) _____ (State) _____	
<b>21 I certify</b> that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Blaschke</u> <b>EXAMINER'S NAME</b> (Type) <u>FRANK J. BLASCHKE</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____ <b>DATE SIGNED</b> <u>Jan 16-62</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit 1/16/62 Rienzi Cemetery</u> <b>22b. DATE THEREOF</b> _____ <b>22c. NAME OF CEMETERY OR CREMATORY</b> _____ <b>22d. LOCATION</b> (City, town, or country) <u>Fond Du Lac, Wisconsin</u> (State) _____		<b>24a. REC'D BY REGISTRAR</b> <u>JAN 17 '62</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kane</u>	
<b>23. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey, Bethesda, Maryland</u>			







DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00949

00942

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b. <b>41 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>47 Bethesda</b> d. STREET ADDRESS <b>5117 Wessling Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Louise Pamela Wacker</b>		<b>4. DATE OF DEATH</b> January 18, 1962	
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>	
<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 29, 1949</b>	
<b>9. AGE</b> (In years last birthday) <b>12</b> yrs.		<b>10. F UNDER 1 YEAR</b> Months Days <b>12</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Student</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>	
<b>11. BIRTHPLACE</b> County & State or foreign country <b>Washington, D.C.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Thomas Wacker</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Stuart</b>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT</b> <b>The Medical Records</b>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pseudomonas Septicemia with Shock</b> DUE TO (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>5 Weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I, or Part I of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> (X) (this hospital) attended the deceased from <b>December 8, 1961</b> to <b>January 18, 1962</b> that (X) (we) last saw the deceased alive on <b>January 18, 1962</b> , and that death occurred at <b>7:35 PM</b> the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <b>J. David Heywood</b>		<b>22b. DATE SIGNED</b> <b>January 19, 1962</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>J. David Heywood</b>		<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>1/22/62</b>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Gate of Heaven Cem.</b>		<b>23d. LOCATION (City, town or county)</b> <b>Silver Spring, Maryland</b>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Robert A. Pumphrey, Bethesda, Maryland</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE JAN 23 '62</b>	
<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Hanes</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Reg. Dist. No. 11942

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurens Park</u>		c. LENGTH OF STAY IN 1b <u>58 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Sycamore Hill Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Wagner</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22 1895</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Ada Dell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Lavinia E. Wagner, 10519 Wayfield St Kensington</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Pneumonia (Viral) at home</u> 50. <input checked="" type="checkbox"/> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Bronchitis</u> DUE TO (c) <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/19/1961</u> to <u>1/15/1962</u> , that I last saw the deceased alive on <u>1/14/1962</u> , and that death occurred at <u>6:12</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard T. Morse</u>		DATE SIGNED <u>1/17/62</u>	
PHYSICIAN'S NAME (Type) <u>Howard T. Morse, MD</u>		<u>Takoma Park, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 17, 1962</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St. NW. D.C.</u>	
24a. REC'D BY REGISTRAR <u>DATE JAN 17 1962</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Morse</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN b <b>7 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if institutions: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Monrovia</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Robert</b> Last <b>Gwinn Walker</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1962</b>	
5. SEX <b>male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29, 1885</b> 9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown Farm laborer</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>John L Walker</b> 14. MOTHER'S MAIDEN NAME <b>Harriet A Hobbs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b> (If yes give year or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>None</b> Address <b>Hospital Records above</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Cerebral thrombosis, left side</b> 332X (b) <b>Arteriosclerosis, cerebral vessels</b> (c) <b>acute lobular pneumonia, bilateral</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1 week</b> <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 30, 1962</b> to <b>Jan 6, 1962</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Jan 6, 1962</b> and that death occurred at <b>3:00 P.M.</b> from the causes and on the date stated above. 22a. SIGNATURE <b>M/ McKendree Boyer</b> 22c. PHYSICIAN'S NAME (Type) <b>M/ McKendree Boyer</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <b>1/6/62</b> 22d. ADDRESS <b>Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>Jan. 9, 1962</b> 24. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Molerworth</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Meth.</b> ADDRESS <b>Damascus, Md.</b> 23d. LOCATION (City, town or county) (State) <b>Browningsville, Md.</b> 25a. REC'D BY REGISTRAR <b>JAN 9 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Carleton E. Thomas</b>	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be retained by the hospital or attending physician. Part II should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00952

00945

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GAITHERSBURG</b>	
c. LENGTH OF STAY IN 1b <b>8 DAYS</b>		d. STREET ADDRESS <b>10 EAST DIAMOND AVENUE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM HUGHES WALKER</b>		4. DATE OF DEATH Month Day Year <b>1 24 19 62</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/27/01</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOISTING ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>EASTERN HARD WALL</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>NATHAN A. WALKER</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES WILLIS HUGHES</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year and dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>FRANCES WILLIS HUGHES</b>	
17. INFORMANT <b>FRANCES WILLIS HUGHES</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED VARICES IN ESOPHAGUS</b> 581.0 DUE TO (b) <b>PORTAL CIRRHOSIS OF LIVER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>HOSPITAL RECORDS</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County, State)	
21. I certify that (I) (this hospital) attended the deceased from <b>7:45A</b> to <b>19</b> , that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>7:45A</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>A. D. Bonifant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. D. BONIFANT, M.D.</b>		22d. ADDRESS <b>SANDY SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>1-27-62</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Monacacy</b>		23d. LOCATION (City, town or county) (State) <b>Callsville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner</b>		25a. REC'D BY REGISTRAR <b>JAN 26 '62</b>	
ADDRESS <b>Gaithersburg</b>		25b. REGISTRAR'S SIGNATURE <b>Clifford L. Thomas</b>	



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be made by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR AIS (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
00953			
00946			
1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Virginia	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) McLean	
c. LENGTH OF STAY IN TB 45 days		d. STREET ADDRESS 1804 Byrnes Drive	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U. S. Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Hume Wanless		4. DATE OF DEATH January 17, 1962	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1911	
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Naval Officer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Wanless		14. MOTHER'S MAIDEN NAME Lotta Engstrom	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 338 01 8586	
17. INFORMANT WIFE: Mrs. Mary Jayne Wanless, Same as #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. adeno carcinoma, pancreas DUE TO DUE TO DUE TO INTERVAL BETWEEN ONSET AND DEATH 5-6 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part I of item 18.) 20c. TIME OF INJURY Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (X) (this hospital) attended the deceased from Dec. 3, 1961 to Jan. 17, 1962, that (X) (we) last saw the deceased alive on Jan. 17, 1962, and that death occurred at 10:30 AM on the causes and on the date stated above.			
22a. SIGNATURE Larry J. Hines		22b. DATE SIGNED January 17, 1962	
22c. PHYSICIAN'S NAME (Type) LARRY J. HINES, CDR MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-19-62	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Fitzgeralds Funeral Home		25a. REC'D BY REGISTRAR DATE JAN 19 '62	
25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Part 3 may be retained by the hospital or attending physician. Part 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00954  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery County, Md.</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>		d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Mildred L. (Claggett)</b>		4. DATE OF DEATH <b>WARD 1 31 1962</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 2 91</b>		9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.							
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN E. CLAGETT.</b>		14. MOTHER'S M.A.DEN NAME <b>FRANCES BEAL</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>							
17. INFORMANT <b>Spencer Ward</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>coronary atherosclerosis</b>		19. INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 hrs.</b> <b>Indefinite</b>		20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) <b>Hypertension &amp; CVA</b>		21. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		22. 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town, County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1960</b> to <b>1/31/1962</b> that (I) (we) last saw the deceased alive on <b>1/31/1962</b> and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Dr. Stephen Jones</b>		22b. DATE SIGNED <b>1/31/62</b>		22c. PHYSICIAN'S NAME (Type) <b>Dr. Stephen Jones</b>		22d. ADDRESS <b>809 Veirs Mill Rd. Rockville.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 4, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Darnestown</b>		23d. LOCATION (City, town or county) (State) <b>Darnestown, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 5 '62</b>		25b. REGISTRAR'S SIGNATURE <b>William E. Thomas</b>	





14  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00955

111448

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>9 mo</u>		d. STREET ADDRESS <u>13100 Parkland Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13100 Parkland Dr</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joyce Maxine Warner</u>	4. DATE OF DEATH Last <u>Warner</u> Month <u>Jan</u> Day <u>12</u> Year <u>1962</u>	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>4-23-1929</u> 32 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>F.B.I.</u>	11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
13. FATHER'S NAME <u>William N. Ritenour</u>	14. MOTHER'S MAIDEN NAME <u>Martha P. Jack</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>No</u> 16. SOCIAL SECURITY NO. <u>204-22-7087</u> 17. INFORMANT <u>Geo R Warner</u> Address <u>Stun 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>476X</u> DUE TO <u>Cerebral hemorrhage &amp; laceration bullet wound thru skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Sudden</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted bullet wound thru skull</u>		
20c. TIME OF INJURY Hour a.m. <u>1</u> p.m. <u>12</u> Month, Day, Year <u>1962</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, 22b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>1-16-62</u>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1-12-62</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or country) <u>Arlington</u> (State) <u>Virginia</u>	
23. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		24e. REC'D BY REGISTRAR <u>Jan 17 '62</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kincaid</u>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

00956 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00949

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>7 DAYS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>			2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b> d. STREET ADDRESS <b>WATERS ROAD</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JULIAN BOYD WATERS</b>			4. DATE OF DEATH Month <b>1</b> Day <b>31</b> Year <b>19 62</b>		
5. SEX <b>MALE</b>			6. COLOR OR RACE <b>WHITE</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>9-10-78</b>		
9. AGE (In years last birthday) <b>83</b> yrs.			10. IF UNDER 1 YEAR Months <b>1</b> Days <b>31</b>		
11. IF UNDER 24 HRS. Hours <b>19</b> Min. <b>62</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>HORACE WATERS</b>			14. MOTHER'S MAIDEN NAME <b>MARY E. <del>WATERS</del> Etichson</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Yes Unknown</b>		
17. INFORMANT <b>HOSPITAL RECORDS</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Bilateral</b> 9 03.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fracture 4-5-6-10-11-12 Dorsal spine 19 days</b> (c) <b>Fracture 7th rib 19 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <b>Cirrhosis of liver</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>Fell on floor in bed room at home</b>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor in bed room at home</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>7</b> p.m. <b>1-12 1962</b>					
20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>					
20f. (City or town) (County) (State) <b>Germantown Monty Md</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DATE SIGNED <b>1-31-62</b>					
Address (Street, city, town, or county) <b>Germantown, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					
22b. DATE THEREOF <b>2/2/62</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Neelsville Cemetery</b>					
22d. LOCATION (City, town, or country) (State) <b>Germantown, Maryland</b>					
23. FUNERAL DIRECTOR <b>Robert A. Pumphrey, Bethesda, Maryland</b>					
24a. REC'D BY REGISTRAR <b>FEB 6 '62</b>					
24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraw...</b>					



TO HOSPITAL OR AT HOME BY PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00957 00950

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b> c. LENGTH OF STAY IN 1b <b>8 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural*- Lewisdale</b> d. STREET ADDRESS <b>RFD, Monrovia</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>J. Monroe Watkins</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>19 62</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>June 5, 1876</b>		9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nursery Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Florist</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Lewisdale, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Julius M. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Norwood</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-20-1533</b>		17. INFORMANT <b>Mrs Mattie Watkins, Item 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Cardio-Vascular-Renal Disease &amp; Uremia</b> <b>Generalized Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last <b>Lobular Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 years</b> <b>20 years</b> <b>12 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER.)		20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 1935</b> to <b>Jan. 9, 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan. 9, 1962</b> , and that death occurred <b>1:30 P</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>M. McKendree Boyer</b>		22b. DATE SIGNED <b>January 10, 1962</b>		22c. PHYSICIAN'S NAME (Type) <b>M. D. 9860 Main Street, Damascus, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 11, 1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethesda Methodist</b>	
23d. LOCATION (City, town or county) <b>Browningsville, Md.</b>		23e. REC'D BY REGISTRAR <b>Jan 12 '62</b>		23f. REGISTRAR'S SIGNATURE <b>Walter S. Kraus</b>	



TO HOSPITAL OR AT HOME BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2, should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00958

00951

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN IT <b>56 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>A</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5718 Wilson Lane</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>Florence Elizabeth Weeden</b>		4. DATE OF DEATH <b>January 11 19 62</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>30 November 1892</b>		9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Harry Davis</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Buchar</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>- - - - -</b>				17. INFORMANT <b>Husband William W. Weeden 5718 Wilson Lane, Bethesda, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Pulmonary Metastases</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Carcinoma of Cervix</b> (b) <b>2 mos</b> (c) <b>1 1/2 yrs</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a: 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (X) (this hospital) attended the deceased from <b>17 November, 1961, to 11 January, 1962</b> that (X) (we) last saw the deceased alive on <b>11 January, 1962</b> , and that death occurred <b>2125PM</b> from the causes and on the date stated above.																			
22a. SIGNATURE <b>Louis E. Potvin</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE <b>Jan. 12, 1962</b>				22c. PHYSICIAN'S NAME (Type) <b>LOUIS E. POTVIN LCDR MC USN</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>1-13-62</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>				23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>JAN 15 '62</b>				25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>							









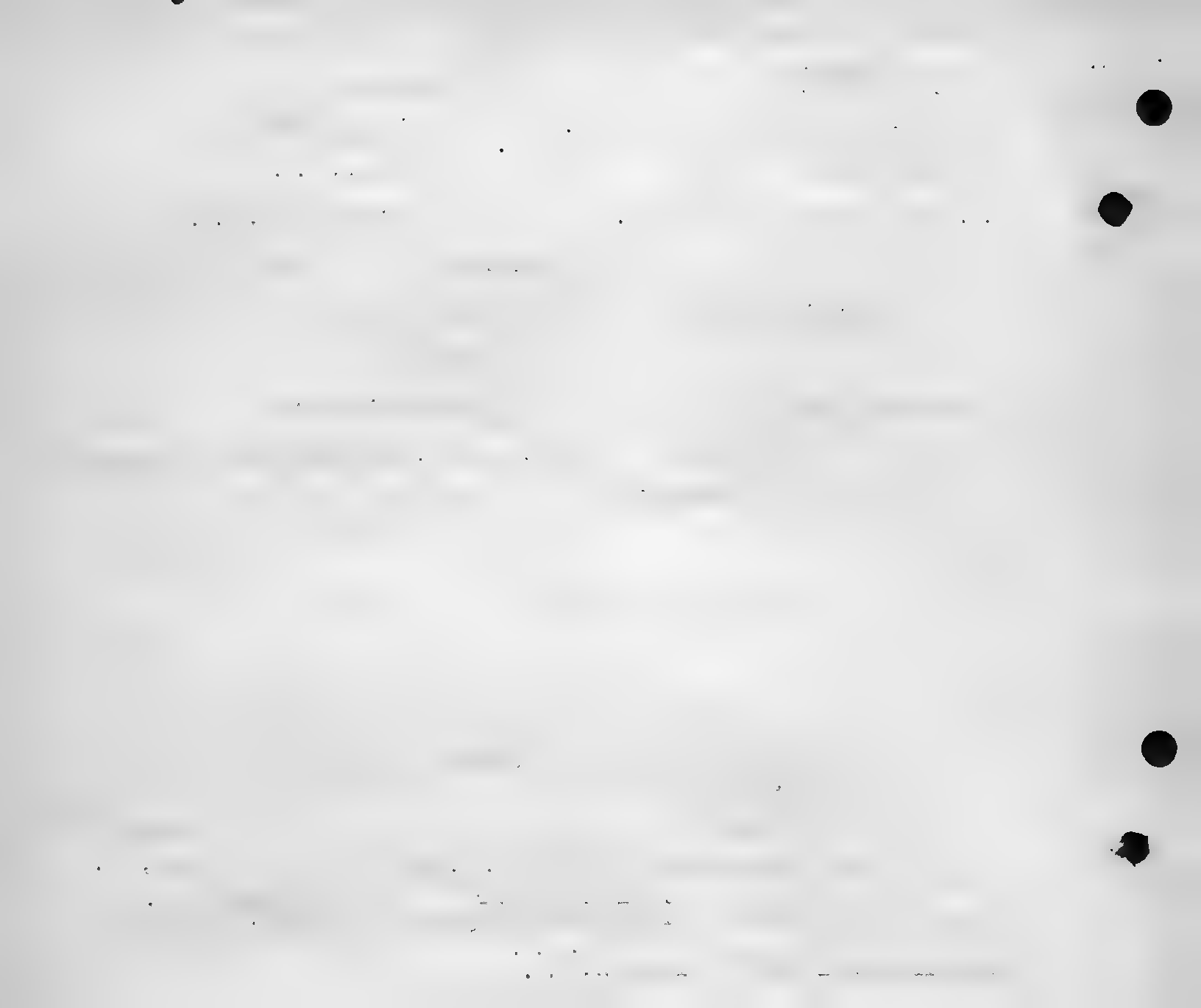
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 7 61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN TB <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington, D.C.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3111 Nichols Ave., S.E.</b> d. STREET ADDRESS <b>3111 Nichols Ave., S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Teresa Lynn Whitenight</b>		4. DATE OF DEATH <b>January 23 1962</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 5 1961</b>	
9. AGE (In years last birthday) <b>10 yrs.</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Terry Allen Whitenight</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Marion Farrell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Agnes M. Whitenight (Mother)</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration</b> DUE TO (b) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>Same as #2</b>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER.) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>23 January, 1962</b> to <b>23 January, 1962</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>23 January, 1962</b> , and that death occurred <b>1:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Fredric Schulaner</b> M.D. 22b. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b> 22c. PHYSICIAN'S NAME (Type) <b>FREDERIC SCHULANER LT MC USN</b> 22d. DATE SIGNED <b>24 January 1962</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>JAN 26 1962</b> 23c. NAME OF CEMETERY OR CREMATORY <b>mt. Olivet Cemetery</b> 23d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b> <b>Arlington National Cemetery, Arlington, Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Taltavull Funeral Home</b> Address <b>3603 14th St., N.W.</b> 25a. REC'D BY REGISTRAR <b>JAN 26 '62</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00961  
00954  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>617 Stonestreet Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Fanny Wilson</u> First Middle Last 4. DATE OF DEATH <u>January 4, 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Col.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 2, 1885</u> 9. AGE (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? Carrol</u>		14. MOTHER'S MAIDEN NAME <u>? unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		17. INFORMANT <u>Charles H. Wilson, son</u> Address <u>same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO Cond. (b) <u>Hypertensive heart disease</u> gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Heraclea Bernier</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>Burial</u> <u>1/9/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Rockville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md</u>		25a. REC'D BY REGISTRAR <u>JAN 15 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, sign 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00962

00955

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY in lb <u>27 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address) <u>Suburban</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>7803 Tilbury St.</u>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nei 11 E. Wilson</u>		<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>14</u> Year <u>1962</u>		<b>9. AGE</b> (in years last birthday) <u>57</u> yrs. IF UNDER 24 HRS. Months <u>14</u> Days <u>18</u> Hours <u>57</u> Min.	
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Manager</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>G.C. Murphy Co.</u>		<b>11. BIRTHPLACE</b> (County & State or foreign country) <u>New York</u>	
<b>13. FATHER'S NAME</b> <u>Jessie Wilson</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Ann Niell</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>095-05-4711</u>		<b>17. INFORMANT</b> <u>Wife Mrs. Yvette Wilson</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>congestive failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>acute myocardial infarction</u> DUE TO (c) <u>coronary heart disease</u>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>3 days</u> <u>3 1/2 wks.</u> <u>6 years</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept. 1961</u> to <u>14 Jan. 1962</u> , that (I) (we) last saw the deceased alive on <u>13 Jan. 1962</u> , and that death occurred at <u>12:05 P.M.</u> from the causes and on the date stated above.					
<b>22a. SIGNATURE</b> <u>John M. Wyman</u>		<b>22b. DATE</b> <u>14 Jan 1962</u>		<b>22c. ADDRESS</b> <u>Bethesda, Maryland</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>John M. Wyman</u>					
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit</u>		<b>23b. DATE THEREOF</b> <u>1/17/62</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Millville Cemetery</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>		<b>25a. REC'D BY REGISTRAR</b> <u>JAN 16 '62</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>William S. Hines</u>	
<b>23d. LOCATION</b> (City, town or county) <u>Millville, New York</u>		<b>23e. STATE</b> <u>New York</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be filed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00963

00956

1. PLACE OF DEATH COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. LENGTH OF STAY in 1b <b>1 year, 3 mo.</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington San. &amp; Hosp.</b>		d. STREET ADDRESS <b>1868 Columbia Rd.</b>		N.W. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Jane Wintree</b>		4. DATE OF DEATH <b>Jan 5 1962</b>		9. AGE (in years last birthday) <b>78</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>10-27-83</b>		9. AGE (in years last birthday) <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l. Educational Va.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>America</b>	
13. FATHER'S NAME <b>William Wintree</b>		14. MOTHER'S MAIDEN NAME <b>Emily Cathright</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Sanitarium medical Records</b>		17. INFORMANT <b>Sanitarium medical Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <b>Broncho-pneumonia</b> <b>"Stroke" CVA.</b> <b>Cerebral Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b> <b>1 1/3 yrs</b> <b>Years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour e.m. p.m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1960</b> to <b>Jan 5 1962</b> , that (I) (we) last saw the deceased alive on <b>Jan 5 1962</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Robert A. Hare</b> M.D. <b>Robert A. Hare MD</b>		22b. DATE SIGNED <b>1/6/62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert A. Hare MD</b>		22d. ADDRESS <b>7600 Carroll Ave., T.P., Md.</b>		22e. REC'D BY REGISTRAR <b>JAN 11 '62</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>1-9-1962</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d. LOCATION (City, town or county) <b>Suitland, Md.</b>		23e. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>		23f. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, part 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00964

1. PLACE OF DEATH  
a. COUNTY Montgomery MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
c. LENGTH OF STAY IN 1b 9 days  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium + Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)  
a. STATE Maryland  
b. COUNTY Montgomery  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park  
d. STREET ADDRESS 804 Maplewood Ave.  
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) Clara Lucille WITZKE  
First Middle Last  
4. DATE OF DEATH 1 7 1962  
Month Day Year

5. SEX Female  
6. COLOR OR RACE White  
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH 6-15-00  
9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing Home  
10b. KIND OF BUSINESS OR INDUSTRY Nebraska  
11. BIRTHPLACE (Country & State, or foreign country) U.S.A.  
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Emil C. Witzke  
14. MOTHER'S MAIDEN NAME Julia E. Hardt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or date of service)  
16. SOCIAL SECURITY NO. 17-297  
17. INFORMANT Charles H. Volobin Address

18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral hemorrhage - R hemisphere  
331X DUE TO Cerebral arteriosclerosis and hypertension  
Conditions, if any, which gave rise to immediate cause (b) hypertension  
(c) hypertension  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e).  
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19  
20d. INJURY OCCURRED While at work ☐ Not While at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12/29/1961 to 1-7-1962, that (I) (we) last saw the deceased alive on 1-7-1962, and that death occurred at 4:40 PM, from the causes and on the date stated above.

22a. SIGNATURE Charles H. Volobin MD  
22b. DATE SIGNED  
22c. PHYSICIAN'S NAME (Type) Charles H. Volobin  
22d. ADDRESS 7600 Carroll Ave Silver Spring MD  
22e. MED. DIRECTOR ☒ ATTENDING PHYS. ☒ STAFF PHYS. ☐

23a. BURIAL, CREMATION, or other disposition (Specify) Buried  
23b. DATE THEREOF JAN 9, 1962  
23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON CEM.  
23d. LOCATION (City, town or county) (State) ADELPHI PR. GEO. CO. MD.  
24. FUNERAL DIRECTOR'S SIGNATURE John J. Stalley  
24a. ADDRESS 284 Canal St NW Wash DC  
25. REC'D BY REGISTRAR John J. Stalley  
25b. REGISTRAR'S SIGNATURE John J. Stalley  
DATE JAN 9 '62

00957



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>montg</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>47 Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>8102 Maple Ridge Rd</u>		d. STREET ADDRESS <u>18102 Maple Ridge Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Francis Donovan Wolter</u>		DATE OF DEATH <u>Jan 29 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
13. FATHER'S NAME <u>Richard C. Donovan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Shields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		17. INFORMANT <u>Richard Donovan Wash. D.C.</u>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>suicide</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brockett</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. BROCKETT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/31/62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		22d. LOCATION (City, town, or country) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 1 '62</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be completed by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Part 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00966  
CERTIFICATE OF DEATH

00959

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>28 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Springfield</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>1722 South 11th Street</b> d. STREET ADDRESS <b>51X-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Bessie Marie Yates</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1962</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 1, 1890</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>15</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Sanders</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jenkins</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>332-01-8032</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1-33.</b> (b) <b>Aspiration of Gastric Contents</b> (c) <b>Paroxysmal Abrial Tachycardia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1/2 Hour</b> <b>1/2 Hour</b> <b>24 Hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 13 1961</b> to <b>January 9, 1962</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 9, 1962</b> , and that death occurred at <b>10:55 PM</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Robert H. Wilkins</b> M.D.		22b. DATE SIGNED <b>1-10-62</b>	
22c. PHYSICIAN'S NAME (Type) <b>Robert H. Wilkins, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>removal</b>	23b. DATE THEREOF <b>1/11/62</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Brush Creek Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Divernon, Illinois</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Company</b>		25a. REC'D BY REGISTRAR <b>2901 14th St. N.W. Washington 9, D.C.</b> <b>JAN 15 '62</b>	25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director. The law also requires that the death certificate be signed by the attending physician and completed by the funeral director.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00967

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>ARLINGTON</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u> d. STREET ADDRESS <u>2111 16th Street, N.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ellis</u> <u>Asby</u> <u>Yost</u>		4. DATE OF DEATH Month Day Year <u>January</u> <u>7</u> <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 12 1872</u> 89 yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County, State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley Yost</u>		14. MOTHER'S MAIDEN NAME <u>Eleana Ammons</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>384-10-7328</u>	
17. INFORMANT <u>Washington Sanitarium + Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> 450.00 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arterio Sclerosis</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>? years</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> <u>1957</u> to <u>Jan</u> <u>7</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>Jan</u> <u>6</u> <u>1962</u> , and that death occurred at <u>4:55 a.m.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert A. Hare</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert A. Hare MD</u>		22d. ADDRESS <u>7600 Carroll Ave. T.T., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>1/10/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington 23, D. C.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hare</u> ADDRESS <u>3901 N. Fairfax Drive Arlington, Va.</u>		25a. REC'D BY REGISTRAR <u>JAN 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hare</u>	

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Wright, J. C.

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Wright, J. C.